MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12110

CERTIFICATE OF DEATH

12095

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: a a — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Mc Pherson Rd.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md. — b. COUNTY: a a
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Annapolis Md
d. STREET ADDRESS: 10 Mc Pherson Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Veronica — Middle: Agatha — Last: Alexander

4. DATE OF DEATH: Month: Nov — Day: 2d — Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feby 5th 1892

9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Baltimore Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jordon De Kowzan

14. MOTHER'S MAIDEN NAME: Frances Stefanowicz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Gerard Alexander — Address: (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): D O A — INTERVAL BETWEEN ONSET AND DEATH: 1

416X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Rheumatic Heart Disease — 30+ yr
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 56 to 11-2-59 19, that I last saw the deceased alive on 9-31 1959, and that death occurred at 6 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Frank M Shipley M.D. — ADDRESS (Street, city or town, state): 121 cathedral St — DATE SIGNED: 11-3-59

PHYSICIAN'S NAME (Type): Frank M Shipley — Annapolis Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: Nov 5-59 — 22c. NAME OF CEMETERY OR CREMATORY: St Mary's Cem't — 22d. LOCATION (City, town, or county) (State): Annapolis Md

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons — ADDRESS: Annapolis Md

24a. REC'D BY REGISTRAR DATE: NOV 6 '59 — 24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 6 FilmG252 11-30-59 et

12148

CERTIFICATE OF DEATH

12096

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: ANNE ARUNDEL — Millersville — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: A.A

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severna Park

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sanns Nursing Home

d. STREET ADDRESS: R.F.D.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Johanna Middle LIZETTA Last Arnold

4. DATE OF DEATH: Month 11 Day 20 Year 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug 29-1873

9. AGE (In years last birthday) 86 yrs.

IF UNDER 1 YEAR: Months Days — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife.

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Ludwig Emmerich

14. MOTHER'S MAIDEN NAME: Broening

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

INFORMANT Address: Mr. William Arnold-715 Genessee St.-Annapolis, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH 2 days

442 X

DUE TO (b) Chronic Nephritis. — 19 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c) Cardio Vascular Degeneration

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Anemia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov 18-'57 19 to Nov 20 '59 19, that I last saw the deceased alive on Nov 19-'59 19, and that death occurred at 5:45 P.M., from the causes and on the date stated above.

ADDRESS (Street, city or town, state): Odenton Md — DATE SIGNED: 11/20/59

ACTUAL SIGNATURE OF PHYSICIAN: Joseph Lipskey M.D.

PHYSICIAN'S NAME (Type): DR. JOSEPH LIPSKEY

ODENTON, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11/24/59

22c. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery

22d. LOCATION (City, town, or county) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Wm. J. Tucker & Sons — ADDRESS: Balto-17 Md.

24a. REC'D BY REGISTRAR DATE: NOV 24 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12149

CERTIFICATE OF DEATH

12097

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: A. A.
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 105 Norman Rd.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md.
b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Pasadena
d. STREET ADDRESS: 105 Norman Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First HERBERT Middle GRANVILLE Last BARNSLEY

4. DATE OF DEATH: Month NOV Day 8 Year 1959

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 11, 1898

9. AGE (In years last birthday): 60 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist Welder

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Christopher Columbus Barnsley

14. MOTHER'S MAIDEN NAME: Mary Anderson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Ellanora S. Barnsley - 105 Norman Rd.
Address: Pasadena, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GENERALIZED CARCINOMATOSIS — INTERVAL BETWEEN ONSET AND DEATH: 6 MONTHS

153.3

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) CARCINOMA OF SIGMOID. — 11 MONTHS

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour, a. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from JAN. 59 to SEPT 59, that I last saw the deceased alive on SEPT 59, and that death occurred at 9:00 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Arthur Lankford Jr. M.D. — ADDRESS (Street, city or town, state): MOUNTAIN RD. — DATE SIGNED: 11-8-59

PHYSICIAN'S NAME (Type): ARTHUR LANKFORD JR — PASADENA, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11/11/59

22c. NAME OF CEMETERY OR CREMATORY: Loudon Park

22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Wm. J. Tickner & Son - Dacto 17 — ADDRESS: Md

24a. REC'D BY REGISTRAR DATE: NOV 9 '59

24b. REGISTRAR'S SIGNATURE: Clifford L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12150

CERTIFICATE OF DEATH

12698

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: ANNE ARUNDEL COUNTY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Jessups Md
c. LENGTH OF STAY IN 1b: 46yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Md 54 - Jessups Md

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Jessups Md
e. STREET ADDRESS: 1 Box. 54
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First PAULINE — Middle E. — Last BARONAS
4. DATE OF DEATH: Month Nov. — Day 29 — Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 1865
9. AGE (In years last birthday): 94 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): Lithuania
12. CITIZEN OF WHAT COUNTRY? ?

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Elizabeth Latronis — Address: Jessups Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 Wk
480 X
DUE TO (b): Influenza — 1 Wk
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Gen'l Arteriosclerosis — 10 Yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11/25 19 57, to 11/29 19 59, that I last saw the deceased alive on 11/27 19 59, and that death occurred at 10 24 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: J M Warren M.D.
ADDRESS (Street, city or town, state): Laurel Md
DATE SIGNED: 11/30/59
PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/2/59
22c. NAME OF CEMETERY OR CREMATORY: Meadow Ridge Memorial
22d. LOCATION (City, town, or county) (State): Dorsey Md

23. FUNERAL DIRECTOR'S SIGNATURE: Charles W Kaelin
ADDRESS: 637 Work Blvd
24a. REC'D BY REGISTRAR / DATE: DEC 2 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12151

CERTIFICATE OF DEATH

12699

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewater
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Box 446

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Edgewater
d. STREET ADDRESS: Box 446
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First CHARLES Middle W Last BEARD

4. DATE OF DEATH: Month NOVEMBER Day 26 Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Feb. 26, 1871

9. AGE (In years last birthday): 88 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Tobacco

11. BIRTHPLACE (State or foreign country): Anne Arundel Co. Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas BEARD

14. MOTHER'S MAIDEN NAME: (Unknown) WATERS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 217 38 3417

INFORMANT: Mr. Thomas W. Beard- Son - Same as # 2 — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary thrombosis
DUE TO (b): Coronary artery disease
DUE TO (c): arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.1

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11-25, 1959, to 11-26, 1959, that I last saw the deceased alive on 11-26 9 a.m., 1959, and that death occurred at 2:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Emily H. Wilson M.D. — ADDRESS (Street, city or town, state): Lothian, Md. — DATE SIGNED: 11-26-59

PHYSICIAN'S NAME (Type): Emily Wilson MD — Lothian, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Nov. 28, 1959
22c. NAME OF CEMETERY OR CREMATORY: Hope Chapel
22d. LOCATION (City, town, or county) (State): Edgewater, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Hopping Funeral Home — ADDRESS: Annapolis, Maryland

24a. REC'D BY REGISTRAR DATE: NOV 30 '59
24b. REGISTRAR'S SIGNATURE: Cullins L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/58

Items 18-21 Film 25?
12-2 [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12111 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12100

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5. A15ME 5M 7/59

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Chesterfield Road

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: Chesterfield Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: JOSEPHINE — Middle: M. — Last: BOEHM

4. DATE OF DEATH: Month: November — Day: 15, — Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Mar 18-1895

9. AGE (In years last birthday): 64 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Checkoslavakien

12. CITIZEN OF WHAT COUNTRY?: U S A

13. FATHER'S NAME: Joseph Masek

14. MOTHER'S MAIDEN NAME: Anna Lehecka

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): (If yes give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: William A. Boehm — Address: (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Skull fracture

900.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b): Subdural hemorrhage

(c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.): Fell down steps

20c. TIME OF INJURY Hour p.m. Month, Day, Year: 11/15 1959

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town): Annapolis (County): Anne Arundel (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒. Inspection ☐. Inquiry ☐. and in my opinion death resulted from: Natural causes ☐. Accident ☒. Suicide ☐. Homicide ☐. Undetermined manner ☐

ACTUAL SIGNATURE: Wm. V. Lovitt M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

DATE SIGNED: 11/17/59

EXAMINER'S NAME (Type): William V. Lovitt, Jr., M.D. — Address (Street, city, town, or county):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 11-19-59 — 22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemt — 22d. LOCATION (City, town, or country): Annapolis — (State): Md

23. FUNERAL DIRECTOR: John M. Layle Cus — ADDRESS: Annapolis Md

24a. REC'D BY REGISTRAR DATE: NOV 23 '59 — 24b. REGISTRAR'S SIGNATURE: Arthur S. Kiana

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12152

CERTIFICATE OF DEATH

12101
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville
c. LENGTH OF STAY IN 1b 30 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sands Nursing Home

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) × Gambrills
d. STREET ADDRESS Route 1 Box 495
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Blanche Middle B. Last Boone
4. DATE OF DEATH Month November Day 18 Year 1959
5. SEX Female
6. COLOR OR RACE W.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH August 13-1878
9. AGE (In years last birthday) 81 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Annapolis Md.
12. CITIZEN OF WHAT COUNTRY? U. Sa.

13. FATHER'S NAME Edmund P. Davis
14 MOTHER'S MAIDEN NAME Maria Smallwood

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT Address Grafton Boone RR. - #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic Cardiac Vascular Disease —
DUE TO
(c) Hypertensive Cardiac Vascular Disease —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)
20c. TIME OF INJURY Month, Day, Year Hour—a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 25, 1957 to November 15, 1959 that I last saw the deceased alive on May 17 — 19 59 and that death occurred at 5 p.m. M, from the causes and on the date stated above.

ACTUAL SIGNATURE Felix Gwinhelg M.D.
ADDRESS (Street, city or town, state) P.O. Box 97 Odenton Md.
DATE SIGNED 11-14-59
PHYSICIAN'S NAME (Type) Felix Gwinhelg

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 11-20-59
22c. NAME OF CEMETERY OR CREMATORY Cedar Bluff
22d LOCATION (City, town, or county) Annapolis (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons ADDRESS Annapolis Md
24a. REC'D BY REGISTRAR DATE NOV 23 '59
24b REGISTRAR'S SIGNATURE Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS ATS (4)
ISM 9/SS

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 2,7,9, Film 252 11-27-59 et

12102

12153

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie, Md.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Plaza Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie, Maryland — Washington 4, D. C.
d. STREET ADDRESS: 1425 Bellmont St., N.W. R/F/D/#1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Benjamin — Middle: — Last: Bowie

4. DATE OF DEATH: Month: November — Day: 15, — Year: 19 59

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: ?

9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Washington, D. C.

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: George Bowie

14. MOTHER'S MAIDEN NAME: Martha Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT: EARLY Bowie WEST RIVER, Md. — Address

MEDICAL CERTIFICATION

1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: ? yrs.

420.1

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Senile mental changes

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Month, Day, Year — Hour: a. m. / p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from November 17, 19 57, to November 15, 19 59 that I last saw the deceased alive on November 7, 19 59 and that death occurred at 4:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James M. Pair M.D. — ADDRESS (Street, city or town, state): 400 N. Carrollton Ave. Baltimore 23, Md. — DATE SIGNED: November 16, 1959

PHYSICIAN'S NAME (Type): James M. Pair, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11-17-59

22c. NAME OF CEMETERY OR CREMATORY: MT. AUBURN

22d. LOCATION (City, town, or county) (State): BALTIMORE, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: WM. A. JACKSON FUNERAL HOME INC.

24a. REC'D BY REGISTRAR — DATE: NOV 18 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12112 **CERTIFICATE OF DEATH** Reg. Dist. No. 12103

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel Genera l Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X RURAL - Annapolis
d. STREET ADDRESS: Rt-1, Box-195
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Albert — Middle Lucien — Last BRADY

4. DATE OF DEATH: Month November — Day 15 — Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 4, 1894

9. AGE (In years last birthday): 65 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SUPERVISOR
10b. KIND OF BUSINESS OR INDUSTRY: US. Govmt Pay Off.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: James R. Brady
14. MOTHER'S MAIDEN NAME: Mary Gable

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): YES 6-7-17-1-20-19
16. SOCIAL SECURITY NO.:
INFORMANT: Hospital records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b): Arterio Sclerotic Heart Disease — 2 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): 420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 1, 19 56 to Nov 15, 19 59 that I last saw the deceased alive on 11-14, 19 59, and that death occurred at 6:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James R. Martin M.D. — ADDRESS (Street, city or town, state): 6 Shaw St., Annapolis, Md. — DATE SIGNED: 11/16/59

PHYSICIAN'S NAME (Type): James R. Martin

22a. BURIAL, ~~CREMATION~~, REMOVAL (Specify)
22b. DATE THEREOF: 11-17-59
22c. NAME OF CEMETERY OR CREMATORY: ST MARY'S CEM.
22d. LOCATION (City, town, or county) (State): ANNAPOLIS MD

23. FUNERAL DIRECTOR'S SIGNATURE: JOHN M. TAYLOR SON — ADDRESS: ANNAPOLIS MD
24a. REC'D BY REGISTRAR DATE: NOV 20 '59
24b. REGISTRAR'S SIGNATURE: Catherine S. Kinnard

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

1

M

I

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12154

CERTIFICATE OF DEATH

12104
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Anne Arundel
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mrs. Bianca Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
d. STREET ADDRESS 513 Shaw St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Benjamin Middle Brooks Last
4. DATE OF DEATH Month 11 Day 16 Year 1959
5. SEX M
6. COLOR OR RACE C
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 9-25-1879
9. AGE (In years last birthday) 80 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10b KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Unknown
14 MOTHER'S MAIDEN NAME Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) No
(If yes, give war or dates of service)
16 SOCIAL SECURITY NO 212-18-5355
17 INFORMANT Address Edwin Carrington 44 East St Annapolis

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombosis.
DUE TO
(b) Generalized Arteriosclerosis
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3-20, 1958 to 11/26, 1959 that I last saw the deceased alive on 11/22, 1959, and that death occurred at 1:30 P.M., from the causes and on the date stated above.
ACTUAL SIGNATURE John Brooks M.D.
ADDRESS (Street, city or town, state) P.O. Box 37 Odenton Md
DATE SIGNED 11/24/59
PHYSICIAN'S NAME (Type) Fehds Svoutsevics

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 11-27-1959
22c. NAME OF CEMETERY OR CREMATORY Riverdale
22d LOCATION (City, town, or county) Riverdale (State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Funeral Dir. 102 Bay Ave Glen Burnie Md.
24a. REC'D BY REGISTRAR DATE NOV 23 '59
24b REGISTRAR'S SIGNATURE C.H. Rinehart

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12155 — Reg. Dist. No. 12105

1. PLACE OF DEATH
a. COUNTY Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie
c. LENGTH OF STAY IN 1b 1 year Plus
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Plaza Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE Maryland
b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
d STREET ADDRESS 1209 Wheatcroft St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print) First Joseph Middle Brooks Last —
4. DATE OF DEATH Month November Day 1st Year 1959

5. SEX M.
6. COLOR OR RACE C.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH 5-16-1895
9. AGE (In years last birthday) 64 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER
10b. KIND OF BUSINESS OR INDUSTRY NONE
11. BIRTHPLACE (State or foreign country) BALTO. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME RICHARD BROOKS
14 MOTHER'S MAIDEN NAME MARY ROBINSON

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN
16 SOCIAL SECURITY NO
17. INFORMANT Address LUVENIA WILLIAMS 619 W. MULBERRY ST.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis
420.1
DUE TO (b) Hypertensive Cardio Vascular Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c) Progressive Neuro-muscular weakness

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-31 19 55 to 11-1 19 57, that I last saw the deceased alive on 10-25 1959, and that death occurred at 7:9 M, from the causes and on the date stated above.

ACTUAL SIGNATURE Felix Gruber M.D. ADDRESS (Street, city or town, state) P.O. Box 97 Odenton Md. DATE SIGNED 11/1/59.
PHYSICIAN'S NAME (Type) Felix Gruber

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF 11-4-59
22c. NAME OF CEMETERY OR CREMATORY M.T. AUBURN
22d LOCATION (City, town, or county) (State) BALTIMORE, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS William A. Jackson Inc. 916 Penna. Ave.
24a. REC'D BY REGISTRAR DATE NOV 5 '59
24b REGISTRAR'S SIGNATURE Arthur S. Travers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12113 — Reg. Dist. No. 12106

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Annapolis
d. STREET ADDRESS: Rt-1, Box-69
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mildred — Middle: Elenore — Last: BUECHLING
4. DATE OF DEATH: Month: 11 — Day: 13 — Year: 1959
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7-6-07
9. AGE (In years last birthday): 52 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Harry A Covey
14. MOTHER'S MAIDEN NAME: Gertrude West

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO: 214 144 959
17. INFORMANT: Charles Buechling — Address: Glen Isle Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Broncho-pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Chronic pulmonary fibrosis — ??
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Feb. ____, 1957, to 13 Nov ____, 1959, that I last saw the deceased alive on 13 Nov., 1959, and that death occurred at 12:35 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward S Beck M.D — ADDRESS (Street, city or town, state): 4 Southgate Ave Annapolis, Md — DATE SIGNED: 11/13/59
PHYSICIAN'S NAME (Type): Edward S. Beck

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Nov 16, 1959
22c. NAME OF CEMETERY OR CREMATORY: Ft Lincoln Cemetery
22d. LOCATION (City, town, or county) (State): Colmar Manor, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: A. Gasch's Sons — ADDRESS: Hyattsville Md.
24a. REC'D BY REGISTRAR DATE: NOV 17 '59
24b. REGISTRAR'S SIGNATURE: Clinton L Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12156

CERTIFICATE OF DEATH

12107
Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel, Md.
c. LENGTH OF STAY IN 1b: 1 yr. - 8 mo.
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION): Children's Center, District Training School, Laurel, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C.
e. STREET ADDRESS: 1233 Walter Street, S.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Shirley; Middle; Last Campbell

4. DATE OF DEATH: Month Nov. Day 5, Year 19 59

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 27, 1952

9. AGE (In years last birthday): 7 yrs

IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): --

10b. KIND OF BUSINESS OR INDUSTRY: --

11. BIRTHPLACE (State or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Willie Campbell

14. MOTHER'S MAIDEN NAME: Myrtle Redfearn Campbell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): -
(If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.: -

17. INFORMANT: Children's Center — Address: Laurel, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): BRONCHIAL PNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: 1 week

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Mental retardation - post-birth subdural hematoma — Fro m birth

DUE TO

(c) Convulsive disorder

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): --

20c. TIME OF INJURY: Hour; a. m. p. m.; Month; Day; Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/14/58, 19__, to 11/5/59, 19__, that I last saw the deceased alive on 11/5/59, 19__, and that death occurred at 5:00 p.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James E. Boyland M.D. — ADDRESS (Street, city or town, state): Children's Center, Laurel, Md. — DATE SIGNED: 11/6/59

PHYSICIAN'S NAME (Type): James E. Boyland M.D. — Children's Center, Laurel, Md. — 11/6/59

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 11/9/59

22c. NAME OF CEMETERY OR CREMATORY: DTS Cemetary

22d. LOCATION (City, town, or county) (State): Laurel Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John J Mooney Jr — ADDRESS: DTS Laurel Md

24a. REC'D BY REGISTRAR DATE: NOV 12 '59

24b. REGISTRAR'S SIGNATURE: Clifton S. Frank

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12119 — Reg. Dist. No. 12189

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): AA. GENERAL HOSPT.

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: MD — b. COUNTY: A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL ANNAPOLIS
d. STREET ADDRESS: DEFENSE HIGHWAY
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First ARTHUR — Middle ROLAND — Last CARR
4. DATE OF DEATH: Month NOV — Day 22 — Year 1959

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: SEPT 24 1902
9. AGE (In years last birthday): 57 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARM SUPPLY STORE
10b. KIND OF BUSINESS OR INDUSTRY: MERCHANT
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN A. CARR
14. MOTHER'S MAIDEN NAME: IRENE KING

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: MARY E. CARR — Address #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Embolism — Interval between onset and death: Sudden
DUE TO (b): Phlebothrombosis - Lower extremity
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 466 X
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: _____ M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: NOV 25/59
EXAMINER'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF: 11-25-1959
22c. NAME OF CEMETERY OR CREMATORY: EDWARDS CHAPEL
22d. LOCATION (City, town, or county): ANNAPOLIS (State): MD

23. FUNERAL DIRECTOR'S SIGNATURE: JOHN M. TAYLOR SON — ADDRESS: ANNAPOLIS MD.
24a. REC'D BY REGISTRAR DATE NOV 27 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

M

I

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12157 **CERTIFICATE OF DEATH** Reg. Dist. No. 12110

PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 3 yrs. 11mo. 9 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 409 Durham Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Lewis (Louis) Middle Last Carter
4. DATE OF DEATH: Month 11 Day 23 Year 1959
5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 28, 1903
9. AGE (In years last birthday): 56 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Junk Hauler
10b. KIND OF BUSINESS OR INDUSTRY: ---------
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Joe Carter
14. MOTHER'S MAIDEN NAME: Ida
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pneumonia
493X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus - Gangrene both legs
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12/14 19 55 to 11/23 19 59, that I last saw the deceased alive on 11/23 19 59, and that death occurred at 6:30P. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): Crownsville State Hospital, Md. — DATE SIGNED: 11/24/59

PHYSICIAN'S NAME (Type): Hildegard Heard Reissman, M. D. — Crownsville State Hospital, Md. — 11/24/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11/29/59
22c. NAME OF CEMETERY OR CREMATORY: Mt. Calvary Cem
22d. LOCATION (City, town, or county) (State): Anne Arundel Co.

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph A. Lutz Jr. — ADDRESS: 804 N. Central Ave. Balto.

24a. REC'D BY REGISTRAR DATE: NOV 30 '59
24b. REGISTRAR'S SIGNATURE: Clifton L. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12115

CERTIFICATE OF DEATH

12111

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: A. A. County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 102 S. Villa Ave

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: A. A. County
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis Md.
d. STREET ADDRESS: 102 S. Villa Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Bessie Middle A. Last Chambers

4. DATE OF DEATH: Month 11 Day 19 Year 1959

5. SEX: Female
6. COLOR OR RACE: Col
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3-14-1922
9. AGE (In years last birthday): 37 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Nelson Sellman
14. MOTHER'S MAIDEN NAME: Leatha Jarvis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO:
INFORMANT: John W. Chambers Address: 102 S. Villa Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Carcinoma of Colon — INTERVAL BETWEEN ONSET AND DEATH
153.8
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6-5-59, 19___, to 11-19-59, 19___, that I last saw the deceased alive on 11-18-59, 19___, and that death occurred at 9:35 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: A. J. Allen M.D. ADDRESS (Street, city or town, state): 6 L Cathedral P DATE SIGNED: 11-20-59
PHYSICIAN'S NAME (Type): A. J. ALLEN

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11-22-1959
22c. NAME OF CEMETERY OR CREMATORY: Brewer Hill
22d. LOCATION (City, town, or county) (State): Annapolis Md.

23. FUNERAL DIRECTOR'S SIGNATURE: William Reese Jr. ADDRESS: 109 Wash. St. Annapolis Md.
24a. REC'D BY REGISTRAR DATE: NOV 23 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12158

Reg. Dist. No. 12112

1. PLACE OF DEATH
a. COUNTY: Anne Arundel County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville, Md.
c. LENGTH OF STAY IN 1b: 44 yr. 9mo. 11 da.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: Anne Arundel Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: UNKNOWN
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Emma — Middle: — Last: Colbert

4. DATE OF DEATH: Month: Nov. — Day: 30 — Year: 19 59

5. SEX: F

6. COLOR OR RACE: N

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1881

9. AGE (In years last birthday): 78 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Colbert

14. MOTHER'S MAIDEN NAME: Emmaly Duckett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): UNKNOWN (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: UNKNOWN

17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH:
443x
DUE TO (b): Hypertensive and Arteriosclerotic Cardiovascular Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour: o. m / p. m — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from Feb. 17, 19 16, to Nov. 30, 19 59 that I last saw the deceased alive on Nov. 30, 19 59, and that death occurred at 8:37 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.

ADDRESS (Street, city or town, state): Crownsville, Md.

DATE SIGNED:

PHYSICIAN'S NAME (Type): Dr. Ludwig Benedict, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Interment

22b. DATE THEREOF: 12.2.59

22c. NAME OF CEMETERY OR CREMATORY: U. of Md. Med. School

22d LOCATION (City, town, or county): Baltimore, Md. (State):

23. FUNERAL DIRECTOR'S SIGNATURE: Wm Rees & Co

ADDRESS: Annapolis Md

24a. REC'D BY REGISTRAR DATE: 12-2-59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

DEC 4 '59

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12116

CERTIFICATE OF DEATH

Reg. Dist. No. 12113

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Annapolis
d. STREET ADDRESS: 118 Granville Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First James — Middle B — Last COLBURN, Sr.

4. DATE OF DEATH: Month November — Day 24, — Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 9, 1888

9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Painter

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Milton Colburn

14. MOTHER'S MAIDEN NAME: Mary Jane Riggel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

INFORMANT — Address: Mrs Esther Hall Colburn- Wife- same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebr myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 4 hrs.
DUE TO (b): Coronary artery sclerosis — 5 yrs.
DUE TO (c):
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour — a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July, 1951, to Nov, 1951, that I last saw the deceased alive on Nov. 24, 1959, and that death occurred at 10:10P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: John L. Hedeman M.D
ADDRESS (Street, city or town, state): 121 Cathedral St., Annapolis, Md.
DATE SIGNED: 11/25/59
PHYSICIAN'S NAME (Type): John L. Hedeman

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Nov. 27, 1959
22c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery
22d. LOCATION (City, town, or county) (State): Annapolis, Md.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Hopping Funeral Home Annapolis, Md.

24a. REC'D BY REGISTRAR DATE: NOV 30 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12159 Item 14 Film G253 12-24-59 et

CERTIFICATE OF DEATH

12114 Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 19 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Worchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snowhill
d. STREET ADDRESS: 204 Collins Street
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Irene — Middle: — Last: Collick
4. DATE OF DEATH: Month: 11 — Day: 16 — Year: 1959

5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 10, 1917
9. AGE (In years last birthday): 42 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown
10b. KIND OF BUSINESS OR INDUSTRY: ----------
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Collick
14. MOTHER'S MAIDEN NAME: Lillian (Unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Unknown
16. SOCIAL SECURITY NO.: Unknown
INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Septicemia
DUE TO
352X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Decubitus ulcers
DUE TO
(c) Spastic hemaparesis, disorganized 331 Convulsions

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Hour a m p. m. — Month, Day, Year — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/27, 1959, to 11/16, 1959 that I last saw the deceased alive on 11/16, 1959, and that death occurred at 1:00PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Hildegard Heard Reiss M.D. — ADDRESS (Street, city or town, state): Crownsville State Hospital, Md. — DATE SIGNED: 11/16/59

PHYSICIAN'S NAME (Type): Hildegard Heard Reissman, M.D. — Crownsville State Hospital, Md. — 11/16/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Nov 19/59
22c. NAME OF CEMETERY OR CREMATORY: Edgewood Memorial Park
22d LOCATION (City, town, or county) (State): Annapolis Md.

23 FUNERAL DIRECTOR'S SIGNATURE: Chas. E. Hick — ADDRESS: 43-45 North West St Annapolis
24a. REC'D BY REGISTRAR DATE: NOV 19 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12160

CERTIFICATE OF DEATH

Reg. Dist. No. 12115

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena (Rfd)
c. LENGTH OF STAY IN 1b: 23 yrs +
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Poplar Ridge Road

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Pasadena R.F.D.
d. STREET ADDRESS: Poplar Ridge Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHRISTIAN Middle ANDREW (Koch) Cook
4. DATE OF DEATH: Month NOV. Day 17 Year 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 20 Oct. 1890
9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fisherman
10b. KIND OF BUSINESS OR INDUSTRY: Self-Emp.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Christian Koch
14. MOTHER'S MAIDEN NAME: Lena Gibbs
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): ——
16. SOCIAL SECURITY NO.: 218-14-3977
17. INFORMANT: Mrs. Hazel Hall — Address: Poplar Rd. Pasadena, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	CACHEXIA	3 MONTHS
154X — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (b)	GENERALIZED CARCINOMATOSIS	6 MONTHS
DUE TO (c)	CARCINOMA RECTUM	15 MONTHS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. / p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from AUGUST, 1959, to NOVEMBER 1959, that I last saw the deceased alive on NOVEMBER 15, 1959, and that death occurred at 2:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Arthur Lankford Jr. M.D. — ADDRESS (Street, city or town, state): MOUNTAIN RD. — DATE SIGNED: 11-17-59

PHYSICIAN'S NAME (Type): ARTHUR LANKFORD JR. PASADENA, MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 20 Nov. 1959
22c. NAME OF CEMETERY OR CREMATORY: Mighty Chief Cemetery
22d. LOCATION (City, town, or county) (State): Freedom, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: T. E. Singleton — ADDRESS: Glen Burnie, Md.
24a. REC'D BY REGISTRAR — DATE: NOV 20 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12161 — Reg. Dist. No. 12116

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brooklyn Park
c. LENGTH OF STAY IN 1b: 15 hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 810 Riverside Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: New Jersey — b. COUNTY: Cape May
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cape May
d. STREET ADDRESS: 38 Delaware Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Steven — Middle: Michael — Last: Dadez

4. DATE OF DEATH: Month: November — Day: 14th. — Year: 1959

5. SEX: M

6. COLOR OR RACE: Hawaien

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7/26/59

9. AGE (In years last birthday) yrs. — IF UNDER 1 YEAR: Months: 3 — Days: 12 — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): CapeMay Court House, N.J.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Ricarte Dadez

14. MOTHER'S MAIDEN NAME: Dorothy E. Koutz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Mr and Mrs R. Dadez (parents.)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Suffocation — INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — DUE TO (c):

9240

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Baby was slepping on his belly, his head covered with ablanket.

20c. TIME OF INJURY — Hour: 9 A.M. or P.M. — Month, Day, Year: 11/14/59

20d. INJURY OCCURRED — While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): In his own carriage.

20f. (City or town) (County) (State): 810 Riverside Rd. A.A. Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Gustave H Faubert M.D. — DATE SIGNED

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

NAME (Type): Gustave H. Faubert, M.D. — 11/14/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11-16-59
22c. NAME OF CEMETERY OR CREMATORY: Parkwood Cem.
22d. LOCATION (City, town, or county) (State): Balto. Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: John C Miller Inc. 2431 E. Oliver St.

24a. REC'D BY REGISTRAR — DATE: NOV 17 '59

24b. REGISTRAR'S SIGNATURE: Arthur L Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12117

CERTIFICATE OF DEATH

12117

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: A A.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 141 Spa View Ave

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: A A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 141 Spa View Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Margaret Middle Ann Last Williams Daniel

4. DATE OF DEATH: Month Nov Day 14th Year 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Apr. 19th 1874

9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School Teacher Ret

10b. KIND OF BUSINESS OR INDUSTRY: Public School

11. BIRTHPLACE (State or foreign country): Frostburg Md

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: James D. Williams

14. MOTHER'S MAIDEN NAME: Leviah Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT (Address): Mrs Leviah Daniel (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute dilatation of the Heart — Interval between onset and death: Immediate

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Arteriosclerotic Cardio Vascular — 5 yrs.

DUE TO (c): Disease

422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Gangrene of the left foot

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 1, 19 57 to Nov. 14, 19 57 that I last saw the deceased alive on Nov. 14, 19 57, and that death occurred at 5:20 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Albert R. Anderson M.D.

ADDRESS (Street, city or town, state): 44 South gate Ave-Annapolis Md

DATE SIGNED: 11/16/59

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11-17-59

22c. NAME OF CEMETERY OR CREMATORY: Frostburg Memorial Pk

22d. LOCATION (City, town, or county) (State): Frostburg Md

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Saylor Sons

ADDRESS: Annapolis Md

24a. REC'D BY REGISTRAR DATE: NOV 20 '59

24b. REGISTRAR'S SIGNATURE: Julian S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12162 Item 12 Filed 252 11-24-59 et

CERTIFICATE OF DEATH

12118 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Anne Arundel Co. c. LENGTH OF STAY IN 1b 4 wks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hosp
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Foreign b. COUNTY Md AA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Quarterfield Rd.
d. STREET ADDRESS 1 Mile East of Rte
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Salvatore Middle X Last Fusco
4. DATE OF DEATH Month 11 Day 16 Year 1959

5. SEX M
6. COLOR OR RACE W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 2/12/1874
9. AGE (In years last birthday) 85 yrs
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stone Mason-Retired
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Italy
12. CITIZEN OF WHAT COUNTRY? Italy

13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
INFORMANT Charles Danza Address same as 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH

(a) IMMEDIATE CAUSE — Acute Lung Incompetency — Days
DUE TO
(b) — Cardiac Failure — 2 years
DUE TO
(c) — Prostatic Hypertrophy — 5 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Senility

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED White at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10-2-1959 to 11-16-59, that I last saw the deceased alive on 11-15-59, and that death occurred 4:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE OF M.D. — ADDRESS (Street, city or town, state) 2 Medical — DATE SIGNED 11/16/59
PHYSICIAN'S NAME (Type) JOSEPH L. KIRKLEY

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 11/19/59
22c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem.
22d. LOCATION (City, town, or county) (State) Glen Burnie, Md

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS Hopping & Kirkley, Glen Burnie, Md
24a. REC'D BY REGISTRAR DATE NOV 19 '59
24b. REGISTRAR'S SIGNATURE Arthur J. Krome

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12118

CERTIFICATE OF DEATH

12119

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: HOMEWOOD CONVALESCENT HOME

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD
b. COUNTY: A A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
d. STREET ADDRESS: 108 MONTICELLO AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CATHERINE Middle HAASE Last DAVEY

4. DATE OF DEATH: Month NOV Day 23 Year 1959

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: MAY 4, 1880

9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): NEW YORK

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO:

17. INFORMANT: BERNARD C. HOFF Address: 106 #2d

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): BRONCHO PNEUMONIA
DUE TO
(b):
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 48 HOURS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from JAN 1925 to 23 NOV 1959 that I last saw the deceased alive on 23 NOV 1959 and that death occurred at 3:30 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward L Beck M.D.
ADDRESS (Street, city or town, state): 4 Southgate Ave Annapolis Md
DATE SIGNED: 11/24/59
PHYSICIAN'S NAME (Type): Annapolis Md

22a. BURIAL, CREMATION, REMOVAL (Specify): NOV 26, 1959
22b. DATE THEREOF
22c. NAME OF CEMETERY OR CREMATORY: HILLCREST MEM.
22d. LOCATION (City, town, or county): ANNAPOLIS (State): MD.

23. FUNERAL DIRECTOR'S SIGNATURE: JOHN M. TAYLOR-SON ADDRESS: ANNAPOLIS MD

24a. REC'D BY REGISTRAR DATE: NOV 27 '59
24b. REGISTRAR'S SIGNATURE: C. Wm. L. Krome

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the coroner or medical examiner, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12119 — Reg. Dist. No. 12120

1 PLACE OF DEATH
a. COUNTY: a a. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): annapolis
c. LENGTH OF STAY IN 1b: 82 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: a a.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Deale
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First Thomas — Middle Franklin — Last DEALE

4 DATE OF DEATH: Month Nov — Day 1 — Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JAN 1 1877
9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Waterman Railway
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): DEALE, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: JAMES DEALE
14. MOTHER'S MAIDEN NAME: ELIZABETH CRUTCHLEY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: none
INFORMANT: Mrs Margaret A Phipps — Address: Deale, Md

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 4 d.
DUE TO (b): Arteriosclerosis — ?
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10-30-59 to 11-1-59, 19 59 that I last saw the deceased alive on 11-1-59, 19 59, and that death occurred at 4:47 M, from the causes and on the date stated above
ACTUAL SIGNATURE: Frank M Shipley M.D. — ADDRESS (Street, city or town, state): 121 Eastland St Annapolis Md — DATE SIGNED: 11-1-59
PHYSICIAN'S NAME (Type): Frank M Shipley

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11-3-59
22c. NAME OF CEMETERY OR CREMATORY: DEALE Cemetery
22d. LOCATION (City, town, or county) (State): DEALE Md.
23 FUNERAL DIRECTOR'S SIGNATURE: Bernard Hardesty — ADDRESS: Galesville Md
24a. REC'D BY REGISTRAR DATE: NOV 4 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, removal, and in any event within 72 hours after death

VS A15 (4)
15M 9/58

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12163

CERTIFICATE OF DEATH

Reg. Dist. No. 12121

1. PLACE OF DEATH
a. COUNTY: A A [BALTIMORE]
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millersville Shores
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: R.F.D. Annapolis Md

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millersville Shores
d. STREET ADDRESS: R.F.D. Annapolis Md
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Joseph Middle P. Last Drake Sr.

4. DATE OF DEATH: Month 11 Day 21 Year 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 26 1904

9. AGE (In years last birthday): 55 yrs.
IF UNDER 1 YEAR / IF UNDER 24 HRS. — Months / Days / Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Guard at U.S. Jail

10b. KIND OF BUSINESS OR INDUSTRY: Guard

11. BIRTHPLACE (State or foreign country): Greensboro Ala

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: WALTER W. DRAKE

14. MOTHER'S MAIDEN NAME: MAMMIE WILKERSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Joseph P. Drake Jr. Address (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: D.O.A.

420.1

DUE TO (b) Coronary Artery Disease C

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Angina Pectoris — 2-3 yr.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Frank M Shipley M.D. ADDRESS (Street, city or town, state): 124 Calhoun St DATE SIGNED: 11-25-59

PHYSICIAN'S NAME (Type): Frank M Shipley Annapolis Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Buried

22b. DATE THEREOF: Nov 24-59

22c. NAME OF CEMETERY OR CREMATORY: Ft Lincoln Cem

22d. LOCATION (City, town, or county) (State): Prince Geo Co Md

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons ADDRESS: Annapolis Md

24a. REC'D BY REGISTRAR: DA NOV 27 '59

24b. REGISTRAR'S SIGNATURE: C. Stuart S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12164 **CERTIFICATE OF DEATH** Reg. Dist. No. 12122

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 5 yrs. 11 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LaPlata
d. STREET ADDRESS: Unknown
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: Samuel — Last: Duckett

4. DATE OF DEATH: Month: 11 — Day: 10 — Year: 19 59

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1893

9. AGE (In years last birthday): 66 yrs
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS: Hours ___ Min ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: David Duckett

14. MOTHER'S MAIDEN NAME: Julia Ann

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unknown (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: Unknown

INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute hemorrhagic pancreatitis — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b): Thrombosis of pancreatic veins

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Obesity, Generalized arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): ---

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 ---

20d. INJURY OCCURRED White at work ☐ Not white at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/29, 19 54, to 11/10, 1959, that I last saw the deceased alive on 11/10, 19 59, and that death occurred at 5:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE, M.D.: Hildegard Heard Reissman — ADDRESS (Street, city or town, state): Crownsville State Hospital, Md. — DATE SIGNED: 11/10/59

PHYSICIAN'S NAME (Type): Hildegard Heard Reissman, M. D. — Crownsville State Hospital, Md. — 11/10/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Nov. 14, 1959

22c. NAME OF CEMETERY OR CREMATORY: Bucks Chapel

22d. LOCATION (City, town or county) (State): Waldorf Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Hartt Funeral Home — ADDRESS: Waldorf

24a. REC'D BY REGISTRAR DATE: NOV 16 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12123

Reg. Dist. No. 12165

1. PLACE OF DEATH
a. COUNTY A.A. Co. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn Grove Annapolis
c. LENGTH OF STAY IN 1b Md 4yrs S.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Severn Grove

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY A.A. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis, Md.
d. STREET ADDRESS Severn Grove, e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Elizabeth Middle A. Last Dunn
4. DATE OF DEATH Month 11 Day 8 Year 1959
5. SEX F
6. COLOR OR RACE W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Oct 20-1882
9. AGE (In years last birthday) 77 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY own home
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME Joseph Harris
14. MOTHER'S MAIDEN NAME Elizabeth Pritchard
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no
16. SOCIAL SECURITY NO. none
17. INFORMANT John E Dunn Address Annapolis, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH Sudden
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
450.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE [signature] M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type) F. Linhardt. DATE SIGNED 11/8/59

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Nov 11, 1959
22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery
22d. LOCATION (City, town, or county) Colmar Manor, Md. (State)

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS F. Gasch's Sons Hyattsville Maryland.
24a. REC'D BY REGISTRAR DATE NOV 10 '59
24b. REGISTRAR'S SIGNATURE Arthur E. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
5M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VE A11 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12166

CERTIFICATE OF DEATH

12124
Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 9yrs 1 mo. 17 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Beltsville
d. STREET ADDRESS: Unknown
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: William — Middle: T. — Last: Edwards

4. DATE OF DEATH: Month: 11 — Day: 14 — Year: 19 59

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1877

9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Laborer

10b. KIND OF BUSINESS OR INDUSTRY: ---------

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Williams

14. MOTHER'S MAIDEN NAME: Sarah

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Unknown

INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Hypostatic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH

420.0

DUE TO (b): Generalized Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Arteriosclerotic Heart Disease

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic Brain Syndrome Associated with Arteriosclerosis-

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18): ----------

20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year —

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —

20f (City or town) — (County) — (State) —

21. I certify that I attended the deceased from 9/27, 1950, to 11/14, 1959, that I last saw the deceased alive on 11/14, 19 59, and that death occurred at 2:40P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Hildegard Heard Reiss M.D.
ADDRESS (Street, city or town, state): Crownsville State Hospital, Md.
DATE SIGNED: 11/16/59

PHYSICIAN'S NAME (Type): Hildegard Heard Reissman, M. D.
Crownsville State Hospital, Md. 11/16/59

22a BURIAL, CREMATION, REMOVAL (Specify)

22b DATE THEREOF: 11/25/59

22c ~~NAME OF CEMETERY OR CREMATORY~~: University of Maryland

22d LOCATION (City, town, or county) (State): Baltimore Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Wm. Reese II
ADDRESS: 108 West Stanyan

24a. REC'D BY REGISTRAR DATE: NOV 27 '59

24b. REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12167

CERTIFICATE OF DEATH

12125

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH
a. COUNTY: Anne Arundel. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ft. Geo G Meade.
c. LENGTH OF STAY IN 1b: 3days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Army Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: —
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BALTIMORE 3V01.4
d. STREET ADDRESS: 1 JEFFRY ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3 NAME OF DECEASED (Type or print): First FATH, Middle KATHERINE, Last ELIZABETH

4. DATE OF DEATH: Month NOV. Day 15 Year 1959.

5. SEX: Female
6. COLOR OR RACE: Cauc.
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12 Nov 1959.
9. AGE (In years last birthday): — yrs.
IF UNDER 1 YEAR: Months — Days 3
IF UNDER 24 HRS: Hours 5 Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): DNA.
10b. KIND OF BUSINESS OR INDUSTRY: DNA.
11. BIRTHPLACE (State or foreign country): USAH.-FGGM.
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Gordon A. FATH.
14. MOTHER'S MAIDEN NAME: Barbara A. HARMON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
INFORMANT: FATHER Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory Failure — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Hyaline membrane disease. — 30hrs.
DUE TO (c): Prematurity. — 3days.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 773.5

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12 Nov, 1959, to 15 Nov, 1959, that I last saw the deceased alive on 15 Nov. 1959, and that death occurred at 1130P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: William W. Mullin Jr M.D. ADDRESS (Street, city or town, state): USAH. Ft GeoG. Meade DATE SIGNED: 15 Nov 59

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Nov. 17, 1959
22c. NAME OF CEMETERY OR CREMATORY: St Mary's Cemetery
22d. LOCATION (City, town, or county) (State): Hughes Town, Pa

23. FUNERAL DIRECTOR'S SIGNATURE: George J Gonce ADDRESS: 4001 Ritchie Hwy. Balto 20, Md
24a. REC'D BY REGISTRAR DATE: NOV 18 '59
24b. REGISTRAR'S SIGNATURE: Clifton L. Hinman

VS A1S (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12168

CERTIFICATE OF DEATH

12126

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY A.A. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 200 Groce Pk Rd.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Md. b. COUNTY A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn.
d. STREET ADDRESS 200 Groce Pk Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Michael Middle B Last Freeze
4. DATE OF DEATH Month 11-10 Day Year 1959.

5. SEX M.
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 1-2-85
9. AGE (In years last birthday) 74 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Thomas.
14 MOTHER'S MAIDEN NAME Margaret Swan.

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
INFORMANT Family - Same Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac - mitral insuff. — INTERVAL BETWEEN ONSET AND DEATH
4 mo X
DUE TO (b) Atherosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from March, 1957, to 11-10, 1959, that I last saw the deceased alive on 11-10, 1959, and that death occurred at 5:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Eugene Schnitzer M.D. ADDRESS (Street, city or town, state) 3914 E. Hanover DATE SIGNED 11-12-59

PHYSICIAN'S NAME (Type) Eugene Schnitzer, M.D. Baltimore 25, Md.

22a BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 11/14/59
22c NAME OF CEMETERY OR CREMATORY Glen Haven
22d. LOCATION (City, town, or county) (State) Essex.

23 FUNERAL DIRECTOR'S SIGNATURE J. Clancy ADDRESS 130 E. Fort Ave.
24a. REC'D BY REGISTRAR DATE NOV 16 '59
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12169 12127

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena(Rural)
c. LENGTH OF STAY IN 1b: 4½ mos.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Box 299, Bar Harbor Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: AA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
d. STREET ADDRESS: 403 Joyce Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Minnie; Middle: ; Last: Fuller
4. DATE OF DEATH: Month: Nov. Day: 2, Year: 1959

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7/4/1880
9. AGE (In years last birthday): 79 yrs
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS/INDUSTRY: Supply House Pharmaceutical
11. BIRTHPLACE (State or foreign country): Balto., Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: J. Warren Fuller
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service): none
16. SOCIAL SECURITY NO.: 212-09-0495
17. INFORMANT: Mrs Emma Long, Same as 2 — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebro-vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b): arteriosclerosis — several years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): none
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 10, 1959 to November 2, 1959 that I last saw the deceased alive on November 1, 1959, and that death occurred at 5.50 A.M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Randall M. McLaughlin M.D — ADDRESS (Street, city or town, state): RFD 8 Box 442 Pasadena, Md. — DATE SIGNED: Nov. 2, 1959

PHYSICIAN'S NAME (Type): Randall M. McLaughlin

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11/5/59
22c. NAME OF CEMETERY OR CREMATORY: Oak Lawn Cemetery
22d. LOCATION (City, town, or county) (State): Baltimore Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] ADDRESS: Hopping and Kirkley, Glen Burnie, Md.
24a REC'D BY REGISTRAR DATE: NOV 5 '59
24b REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12170

CERTIFICATE OF DEATH

13247

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GLEN BURNIE
c. LENGTH OF STAY IN 1b: 2 yrs.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 207 CARROLL RD.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: M D.
b. COUNTY: BALT. CITY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 1237 LOMBARD ST
d. STREET ADDRESS: BALT., MD.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROSARIA Middle (N) Last GIANFORTE

4. DATE OF DEATH: Month NOVEMBER Day 21 Year 1959

5. SEX: F.

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 12 FEB. 1885

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HSWF

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): SICILY, ITALY

12. CITIZEN OF WHAT COUNTRY? YES - USA

13. FATHER'S NAME: Mr Dominick Marino (dec)

14. MOTHER'S MAIDEN NAME: Mrs Rosaria Battaglia (dec)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: MRS. ANTONINA DuVALL - 1003 OLD ANAP. BLVD. GLEN BURNIE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ACUTE CORONARY THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
DUE TO
4341
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): CONGESTIVE HEART FAILURE — 1 mo
DUE TO
(c): ADVANCED AGE — 70 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): CANCER - BOTH LUNGS - 3 YRS

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER): NO

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): NONE

20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 20 Nov, 1959, to 21 Nov., 1959, that I last saw the deceased alive on 20 Nov 1959, and that death occurred at 12 15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: H.F. Manuzak M.D. — ADDRESS (Street, city or town, state): EASTWAY & EDGERLY RD — DATE SIGNED: 21 Nov 59

PHYSICIAN'S NAME (Type): H.F. MANUZAK — GLEN BURNIE, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Nov 25-59

22c. NAME OF CEMETERY OR CREMATORY: New Cathedral Cemetery

22d. LOCATION (City, town, or county) (State): Baltimore Md

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Leonard G Funk Glen Burnie Md

24a. REC'D BY REGISTRAR DATE: NOV 24 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12128

12120

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural – Annapolis
d. STREET ADDRESS: Gilliam's Corner, Defense Hgwy.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: JORDAN — Last: GILLIAM

4. DATE OF DEATH: Month: November — Day: 27 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 3, 1885

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cafe Gilliam Corner

10b. KIND OF BUSINESS OR INDUSTRY: Ret Confectionery Bldg

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William H. Gilliam

14. MOTHER'S MAIDEN NAME: Emily Mackey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT: William J. Gilliam — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cancerous due to oesophageal
DUE TO (b): obstruction by fight diaphragmatic
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): hernia. by gall stones

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Congestive Heart Failure, Arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov. 26, 1959 to Nov. 27, 1959, that I last saw the deceased alive on Nov. 27, 1959, and that death occurred at 2:05P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Maurice Klawans M.D. — ADDRESS (Street, city or town, state): 31 Southgate Ave., — DATE SIGNED: 11/27/59

PHYSICIAN'S NAME (Type): Maurice Klawans — Annapolis, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 11-30-59

22c. NAME OF CEMETERY OR CREMATORY: Glen Haven

22d. LOCATION (City, town, or county) (State): Glen Burnie Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons — ADDRESS: Annapolis, Md.

24a. REC'D BY REGISTRAR DATE: DEC 1 '59

24b. REGISTRAR'S SIGNATURE: Catlin S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12171

CERTIFICATE OF DEATH

12129
Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH a. COUNTY: Anne Arundel — MARYLAND	2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel, Md. — c. LENGTH OF STAY IN 1b: 33 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D. C.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: District Training School Laurel, Md. — STREET ADDRESS: Children's Center, 1420 - 21St. N.W.	e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print)	First: Donald	Middle: M.	Last: Greenstreet	4. DATE OF DEATH	Month: November	Day: 9	Year: 1959		
5. SEX: male	6. COLOR OR RACE: white	7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: Feb. 14, 1900	9. AGE (In years last birthday): 59 yrs.	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min			

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Institution	10b. KIND OF BUSINESS OR INDUSTRY: --	11. BIRTHPLACE (State or foreign country): Washington, D.C.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Abher G. Greenstreet		14. MOTHER'S MAIDEN NAME: Mary McKee Greenstreet	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: ---	17. INFORMANT Address: Children's Center, Laurel, Md.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 12 hours

DUE TO

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Arteriosclerotic heart disease

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Epileptic Colitis, epilepsy, mental retardation — 19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year / Hour o. m. p. m.	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			

21. I certify that I attended the deceased from August, 1956, to Nov 9, 1959, that I last saw the deceased alive on Nov 8, 1959, and that death occurred at 8 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Wilfred R. Ehrmantraut M.D. — ADDRESS (Street, city or town, state): Children's Center, Laurel, Md. — DATE SIGNED: 11/10/59

PHYSICIAN'S NAME (Type): Wilfred R. Ehrmantraut, M.D. Children's Center, Laurel, Md. 11/10/59

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Cremation	11/11/59	Lincoln Cemetery	Washington D.C.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Hunt & Gaudson 313 Talbott St Laurel Md	NOV 13 '59	Clinton L. Hanna

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12172 **CERTIFICATE OF DEATH** 12130

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Anundel — b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cutis Bay — c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6715 Allenhurst Road

2. USUAL RESIDENCE (Where deceased lived. If institution - Residence before admission)
a. STATE Maryland — b. COUNTY [redacted] Ann Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Curtis Bay
d. STREET ADDRESS 6715 Allenhurst Road — e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Joseph — Middle — Last Hall
4. DATE OF DEATH: Month November — Day 6th. — Year 1959

5. SEX: Male
6. COLOR OR RACE: Col.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March-21st-1886
9. AGE (In years last birthday): 73 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): A.A. Arundel [redacted] County Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Robert Hall
14. MOTHER'S MAIDEN NAME: Milvina Kess

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — Address: Bertha Hall 6715 Allenhurst Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Coronary Occlusion	Several Hrs
DUE TO (b)	Thrombophlabitis Rt. Leg	Several days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)	Cardio Vascular Disease	Unknown

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS A AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 10 1959 to Nov. 6 1959 that I last saw the deceased alive on Nov. 5 1959, and that death occurred at 7:20 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE Richard H. Hunt M.D. — ADDRESS (Street, city or town, state) 1607 W. Mulberry St. Balto Md. — DATE SIGNED 11-7-59

PHYSICIAN'S NAME (Type) RICHARD H. HUNT

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11/8/59
22c. NAME OF CEMETERY OR CREMATORY: Mt Zion Cemetary
22d. LOCATION (City, town, or county) (State): [redacted] Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Chas O Wilson — ADDRESS: 1000 Brantley Ave
24a. RECEIVED BY REGISTRAR DATE: NOV 9 59
24b. REGISTRAR'S SIGNATURE: Clinton L. Burns

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12121

CERTIFICATE OF DEATH

12131

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 9 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel Genera l Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Churchton
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Carrie — Middle: Mae — Last: HARDESTY
4. DATE OF DEATH: Month: November — Day: 11 — Year: 1959
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: September 1, 1889
9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Prop
10b. KIND OF BUSINESS OR INDUSTRY: General Store
11. BIRTHPLACE (State or foreign country): New York
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Nemiah Brundage
14. MOTHER'S MAIDEN NAME: Lillie C. Owens

15. WAS DECEASED EVER IN U. S ARMED FORCES? (Yes, no, or unknown): noS (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 213-34-1980
INFORMANT Address: Mr. Milton Hardesty--Son--Churchton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 1mo
DUE TO (b): Carcinoma of the bladder — 6mo
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
181.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April, 1959, to Nov. 11, 1959 that I last saw the deceased alive on Nov. 10, 1959, and that death occurred at 1:15A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edwin Davis, Jr. M.D.
ADDRESS (Street city or town, state): 98 Cathedral St., Annapolis, Md.
DATE SIGNED: 11/11/59
PHYSICIAN'S NAME (Type): Edwin Davis, Jr.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Nov.13,1959
22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery
22d. LOCATION (City, town, or county) (State): Annapolis, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: HOPPING FUNERAL HOME
ADDRESS: Annapolis, Maryland
24a. REC'D BY REGISTRAR DATE: NOV 16 '59
24b. REGISTRAR'S SIGNATURE: Cletus S Knapp

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12173 **CERTIFICATE OF DEATH** Reg. Dist. No. 12132

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fort George G. Meade
c. LENGTH OF STAY IN 1b: 5½ hours
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Army Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Res dence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c CITY OR TOWN (If outside corporate limits, write RURAL and g ve nearest town): Fort George G. Meade
d. STREET ADDRESS: 7006-C Antelak St. Argonne Hills
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First RICHARD — Middle – — Last HARPER
4. DATE OF DEATH: Month November — Day 28 — Year 19 59
5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 27 November 1959
9. AGE (In years last birthday): — yrs — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours 5½ — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Emanuel Harper
14. MOTHER'S MAIDEN NAME: Evelyn Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
INFORMANT: Emanuel Harper (Father) Address 7006-C Antelak St Argonne Hills

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Prematurity — INTERVAL BETWEEN ONSET AND DEATH: 5½ hours
716 X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 27 Nov, 19 59, to 28 November, 19 59, that I last saw the deceased alive on 28 November, 19 59, and that death occurred at 0230 AM, from the causes and on the date stated above.
ACTUAL SIGNATURE: Archie S. Golden M.D. — ADDRESS (Street, city or town, state) — DATE SIGNED: 28 Nov 1959
PHYSICIAN'S NAME (Type) ARCHIE S. GOLDEN, CAPT., MC — USAH, Fort George G. Meade, Maryland

22a. BURIAL, CREMATION REMOVAL (Specify): Cremation
22b. DATE THEREOF: 30 Nov 1959
22c NAME OF CEMETERY OR CREMATORY: Laboratory, U.S. Army Hospital
22d. LOCATION (City, town, or county) (State): Fort George G. Meade, Md

23 FUNERAL DIRECTOR'S SIGNATURE: Harry H. Ellis, Capt., MSC
ADDRESS U.S. Army Hosp. Fort Geo G Meade, Md
24a. REC'D BY REGISTRAR DATE DEC 4 '59
24b REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

2050232XV

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12174 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12133

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 5 yrs. [illegible] days

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3 Vol - 4
d. STREET ADDRESS: 1512 Druid Hill Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

3. NAME OF DECEASED (Type or print): First VERNON Middle Lastname Hudnell

4. DATE OF DEATH: Month 11 Day 3 Year 19[illegible]

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 17, 1922

9. AGE (In years last birthday): 37 yrs.

IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: ---------

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Harry Hudnell

14. MOTHER'S MAIDEN NAME: Celestine Perry

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 215-12-3599

17. INFORMANT: Address: Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Paralytic Ileus — INTERVAL BETWEEN ONSET AND DEATH
570.5
DUE TO (b): Intestinal Obstruction
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Old Post-Operative Adhesions

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NALDISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: [signature] M.D.
EXAMINER'S NAME (Type): E. Linhardt
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 11/4/[illegible]9

22a. BURIAL, CREMATION, REMOVAL (Specify): [illegible]
22b. DATE THEREOF: 11/8/[illegible]9
22c. NAME OF CEMETERY OR CREMATORY: Laurel Memorial Park
22d. LOCATION (City, town, or county) (State): Laurel Md

23. FUNERAL DIRECTOR'S SIGNATURE: [signature]
ADDRESS: 1610 W. Saratoga St.

24a. REC'D BY REGISTRAR DATE: NOV 6 [illegible]9
24b. REGISTRAR'S SIGNATURE: Arthur J. Krantz

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 Film 252 11-26-59 ams

12122

CERTIFICATE OF DEATH

12134

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS, MARYLAND
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS, MARYLAND
d. STREET ADDRESS: 75 PRINCE GEORGE ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joseph — Middle: Jerome — Last: JACOBSON

4. DATE OF DEATH: Month: 11 — Day: 10 — Year: 19 59

5. SEX: Male

6. COLOR OR RACE: Cauc.

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-25-86

9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S. Navy

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: JACOBSON, Jacob

14. MOTHER'S MAIDEN NAME: GANNON, Margaret

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): 20 Yrs.

16. SOCIAL SECURITY NO.:

17. INFORMANT: Lillian D. JACOBSON (W) Address: Annapolis, Md. 75 Prince George St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): [illegible]
DUE TO (b): Chronic Pulmonary Emphysema — 20+ — INTERVAL BETWEEN ONSET AND DEATH: 4 [illegible]
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Chronic bronchitis — 20 +

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year; Hour a. m. / p. m.; 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 15, 19 59, to Nov 10, 19 59, that I last saw the deceased alive on Nov-10, 19 59, and that death occurred at 4:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Sylvan Busch LT(MC) USNR — M.D. — ADDRESS (Street, city or town, state): VSNH - Annapolis Md. — DATE SIGNED:

PHYSICIAN'S NAME (Type): S. BUSCH LT MC USN

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11-16-59

22c. NAME OF CEMETERY OR CREMATORY: National

22d. LOCATION (City, town, or county) (State): Annapolis Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS

24a. REC'D BY REGISTRAR — DATE: NOV 16 '59

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12175 Items 8,9 filmed 54 1-13-60 et

Reg. Dist. No. 13262

1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville
c. LENGTH OF STAY IN 1b 12yrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MD b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1231 Druid Hill Avenue
d. STREET ADDRESS Baltimore MD.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hosp

3. NAME OF DECEASED (Type or print) First Leon Middle — Last Samison

4. DATE OF DEATH Month 11. Day 3. Year 1957

5. SEX Male
6. COLOR OR RACE Negro
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 1925??
9. AGE (In years last birthday) 34? yrs.
IF UNDER 1 YEAR Months — Days —
IF UNDER 24 HRS. Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown
10b. KIND OF BUSINESS OR INDUSTRY — — —
11. BIRTHPLACE (State or foreign country) New Jersey
12. CITIZEN OF WHAT COUNTRY? —

13. FATHER'S NAME Samuel Samison
14. MOTHER'S MAIDEN NAME Yvonne

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. unknown
17. INFORMANT Address Hospital Records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peripheral Circulatory Failure — INTERVAL BETWEEN ONSET AND DEATH for hours

795.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Exposure to Cold and Starvation — 1 x days

DUE TO (c) —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Naturol couses ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE F. Linhardt M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type) F. Linhardt
DATE SIGNED 12/14/57

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 12-24-59
22c. NAME OF CEMETERY OR CREMATORY Crownsville State Hosp.
22d. LOCATION (City, town, or county) (State) Crownsville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE Edward J. Gallagher
ADDRESS Crownsville State Hospital

24a. REC'D BY REGISTRAR DATE DEC 28 '59
24b. REGISTRAR'S SIGNATURE Calvin S. Krouse

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12123

CERTIFICATE OF DEATH

12135

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riva
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION): A.A. General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: A.A. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x Riva
d. STREET ADDRESS: Riva Rd Rt #1
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Awvie — Middle: May — Last: Johnson

4. DATE OF DEATH: Month: 11 — Day: 2 — Year: 1959

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6-20-1910

9. AGE (In years last birthday): 49 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Roy Hewitt

14. MOTHER'S MAIDEN NAME: "Uck"

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Roy L. Johnson — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 1 hour
DUE TO (b): Arteriosclerotic CVD — up -
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Staph pneumonia, old myocardial infarct...

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☑ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 1956 19__ to 11-7 19 59 that I last saw the deceased alive on 11-6-59 19__, and that death occurred at 6 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Frank M. Shilley M.D. — ADDRESS (Street, city or town, state): 171 Cathedral St — DATE SIGNED: 11-9-59

PHYSICIAN'S NAME (Type): Frank M. Shilley — Annapolis, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11-10-59
22c. NAME OF CEMETERY OR CREMATORY: Hillcrest
22d. LOCATION (City, town, or county): Annapolis (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Foy & Sons — ADDRESS: Annapolis, Md.

24a. REC'D BY REGISTRAR DATE: NOV 12 '59
24b. REGISTRAR'S SIGNATURE: Carlton S. Krauss

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12136

12124

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 2 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Annapolis
d. STREET ADDRESS: 69 Clay St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Debra — Middle: Ann — Last: JOHNSON

4. DATE OF DEATH: Month: November — Day: 24 — Year: 19 59

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: September 8, 1959

9. AGE (In years last birthday): 2 mos.
IF UNDER 1 YEAR: Months: 2 — Days: 16
IF UNDER 24 HRS.: Hours — Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Richard Sylvester Johnson

14. MOTHER'S MAIDEN NAME: Theresa Hinnant

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT: Theresa Hinnant — Address: 69 Clay St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 525 X — DUE TO: Interstitial (Bilateral) Pneumonia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): — DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH: 5 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 11-24-59, 19__, to 11-24-59, 19__, that I last saw the deceased alive on 11-24-59, 19__, and that death occurred at 2:10P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: R. L. Richardson, M.D. — ADDRESS (Street, city or town, state): 110 Clay St., — DATE SIGNED: 11/25/59

PHYSICIAN'S NAME (Type): R. L. Richrdson — Annapolis, Md.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 11-28-1959 — 22c. NAME OF CEMETERY OR CREMATORY: Brewer Hill — 22d. LOCATION (City, town, or county) (State): Millersville Md

23. FUNERAL DIRECTOR'S SIGNATURE: Wilson Funeral Home — ADDRESS: 109 Main St. Millersville Md

24a. REC'D BY REGISTRAR DATE: NOV 30 '59

24b. REGISTRAR'S SIGNATURE: Orlan L. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12137

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12125 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY ANNE ARUNDEL MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DOA U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS
d. STREET ADDRESS 103 BETH ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	Donald	E.	JOHNSON		11	10	1959

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Cauc.		3 July 1959	yrs.	4	7		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
		USNH, ANNAPOLIS, MARYLAND	US

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Donald G. JOHNSON	Betty J. HANNA

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
		(F) Donald G. JOHNSON 103 Beth Rd., GLEN BURNIE, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART FAILURE — INTERVAL BETWEEN ONSET AND DEATH

7546

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) COARTATION OF AORTA — 4 mo. 7 days

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE E. Linhardt M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type) E. LINHARDT

DATE SIGNED 11/10/59

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Nov 14	Meadowridge Memorial Park	Annapolis Anne Arundel Co. Md

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
[illegible] FUNERAL CHAPEL, GLEN BURNIE, MARYLAND	[illegible]	NOV 16 '59	Catherine B. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate omitting the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5) 5M 9/55

20512147X5

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12126

CERTIFICATE OF DEATH

12138
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 16 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural - Lothian
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Lonnie — Middle: Jesse — Last: JOHNSON

4. DATE OF DEATH: Month: November — Day: 21 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: November 5, 1959

9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months: — Days: 16
IF UNDER 24 HRS.: Hours: 7 — Min.: 35

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Benjamin Roosevelt JOHNSON

14. MOTHER'S MAIDEN NAME: Gertrude Beatherlia SELLMAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Laryngopharyngitis , E. Coli organism — INTERVAL BETWEEN ONSET AND DEATH: 2 wks.
474X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): malnutrition and dehydration

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Nov. 20

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ~~Nov. 5~~, 1959, to Nov. 21, 1959 that I last saw the deceased alive on Nov. 21, 1959, and that death occurred at 11:55P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James I. Hudson, Jr. M.D. — ADDRESS (Street, city or town, state): River Club Estates — DATE SIGNED: 11/23/59

PHYSICIAN'S NAME (Type): James I. Hudson, Jr. — Edgewater, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11-24-1959
22c. NAME OF CEMETERY OR CREMATORY: Evergreen Cemetery
22d. LOCATION (City, town, or county) (State): Lothian Md

23. FUNERAL DIRECTOR'S SIGNATURE: William Rennett — ADDRESS: 108 Riva Rd. Annapolis Md

24a. REC'D BY REGISTRAR DATE: NOV 25 '59

24b. REGISTRAR'S SIGNATURE: Clinton S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12176 — Reg. Dist. No. 12139

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CROWNSVILLE
c. LENGTH OF STAY IN 1b: 5 YRS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: CROWNSVILLE STATE HOSP

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD — b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ABERDEEN
d. STREET ADDRESS: DORSEY AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): WILLIAM — First; Middle; KENLY — Last
4. DATE OF DEATH: NOV — Month; 27 — Day; 1959 — Year

5. SEX: M
6. COLOR OR RACE: C
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 15, 1879
9. AGE (In years last birthday): 80 yrs
IF UNDER 1 YEAR: Months; Days — IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Canning Factory
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William F. Kenly
14. MOTHER'S MAIDEN NAME: Tina Peaco

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO:
17. INFORMANT: Isiah H. Kenly — Address: Box 147 Perryman, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CACHEXIA
DUE TO (b): SENILITY
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: YEARS

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I **certify** that I attended the deceased from [illegible] NOV, 19 59, to [illegible] NOV, 19 59, that I last saw the deceased alive on [illegible] NOV, 19 59, and that death occurred at [illegible] P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Carl D. Schaupp M.D. — ADDRESS (Street, city or town, state): CROWNSV[illegible] — DATE SIGNED

PHYSICIAN'S NAME (Type): 11/27/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/1/1959
22c. NAME OF CEMETERY OR CREMATORY: Union Methodist
22d. LOCATION (City, town, or county) (State): Aberdeen Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: John G. Garvey — ADDRESS: Aberdeen Md.
24a. REC'D BY REGISTRAR DATE: DEC 4 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12140

12127

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Annapolis
d. STREET ADDRESS: 1 63 West St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Kyriakos — Middle — Last KOUSERTARY
4. DATE OF DEATH: Month November — Day 15 — Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: November 22, 1901
9. AGE (In years last birthday): 58 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BARTENDER
10b. KIND OF BUSINESS OR INDUSTRY: Lunch Room
11. BIRTHPLACE (State or foreign country): Greece
12. CITIZEN OF WHAT COUNTRY? GREECE

13. FATHER'S NAME: "Unk"
14. MOTHER'S MAIDEN NAME: "Unk"

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
INFORMANT: Hospital records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma of stomach — INTERVAL BETWEEN ONSET AND DEATH: 8 mos.
151X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 13, 1959, to Nov. 15, 1959, that I last saw the deceased alive on Nov. 15, 1959, and that death occurred at 10:45AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: John L Hedeman M.D. — ADDRESS (Street, city or town, state): 121 Cathedral St., — DATE SIGNED: 11/16/59
PHYSICIAN'S NAME (Type): John L. Hedeman — Annapolis, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 11-17-59
22c. NAME OF CEMETERY OR CREMATORY: St. James
22d. LOCATION (City, town, or county): Annapolis (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John W Tsoukalas — ADDRESS: Annapolis, Md.
24a. REC'D BY REGISTRAR DATE: NOV 20 '59
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12128 — Reg. Dist. No. 12141

1 PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD. — b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
d. STREET ADDRESS: RD2 BOX 116 ST. MARGARET ST.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First HAROLD — Middle HARRISON — Last LITTLE

4. DATE OF DEATH: Month NOVEMBER — Day 1 — Year 1959

5. SEX: Male
6. COLOR OR RACE: Cauc.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6-27-89
9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S. NAVY
10b. KIND OF BUSINESS OR INDUSTRY: U.S. NAVY
11. BIRTHPLACE (State or foreign country): NEW YORK
12 CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: HARRY LITTLE
14. MOTHER'S MAIDEN NAME: MARIE BLOODGOOD

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW1 & 11
16. SOCIAL SECURITY NO: 220-07-2601A
17. INFORMANT: Lillian Little RD2 Box 116, St.Margaret ST., Annapolis, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Melanoma Malignant — INTERVAL BETWEEN ONSET AND DEATH: 2 days
190.7
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10-30, 1959 to 11-1, 1959, that I last saw the deceased alive on 31 October, 1959, and that death occurred at 0440A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: R. C. Laning, M.D. — ADDRESS (Street, city or town, state): U.S. NAVAL HOSPITAL, ANNAPOLIS, MD. — DATE SIGNED: 11-2-59

PHYSICIAN'S NAME (Type): R.C. LANING LCDR MC USN — U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Nov. 3, 1959
22c. NAME OF CEMETERY OR CREMATORY: Naval Academy Cemet.
22d. LOCATION (City, town, or county) (State): Annapolis, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] — ADDRESS: Hopping Funeral Home, Annapolis, Md.
24a. REC'D BY REGISTRAR DATE: NOV 4 '59
24b REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A15 (4)
15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12129 **CERTIFICATE OF DEATH** Reg. Dist. No. 12142

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 120 Granada Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 120 Granada
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Mary Middle Scala Lost Lorea

4. DATE OF DEATH: Month November Day 12 Year 1959

5. SEX: female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: July 19, 1888
9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife.
10b. KIND OF BUSINESS OR INDUSTRY: Own Home.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Louis Scala
14. MOTHER'S MAIDEN NAME: Mary Anna Armanatta

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO:
17. INFORMANT: Mrs Anna Taylor Address #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): ARTERIOSCLEROTIC HEART DISEASE — INTERVAL BETWEEN ONSET AND DEATH: 5 YRS
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from MAY 1, 1954, to NOV, 1959, that I last saw the deceased alive on NOV, 1959, and that death occurred at 1 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward L Beck M.D — ADDRESS (Street, city or town, state): 11 Southgate Ave — DATE SIGNED: 11/20/59
PHYSICIAN'S NAME (Type): Annapolis Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11-21-1959
22c. NAME OF CEMETERY OR CREMATORY: St. Mary's
22d. LOCATION (City, town, or county): Annapolis (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John M Taylor & Sons — ADDRESS: Annapolis, Md.
24a. REC'D BY REGISTRAR DATE: NOV 23 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12143

12177

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: AA — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: yrs
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: Paul Drive - Box 303

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MD
b. COUNTY: AA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Stone Haven
d. STREET ADDRESS: Paul Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edna — Middle: V. — Last: Lycett

4. DATE OF DEATH: Month: 11 — Day: 19 — Year: 1959

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug 15, 1886

9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): MD.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas Burke

14. MOTHER'S MAIDEN NAME: Eliz. Sabley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO: —

INFORMANT: Family — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of the stomach
DUE TO
(b):
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 6 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from September 15, 1953, to November 19, 1959, that I last saw the deceased alive on Nov. 19, 1959, and that death occurred at 4:10 P. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: R. M. McLaughlin M.D. — ADDRESS (Street, city or town, state): RFD 8 Box 42 Pasadena, Md. — DATE SIGNED: Nov. 19, 1959

PHYSICIAN'S NAME (Type): R. M. McLaughlin

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11-23-59

22c. NAME OF CEMETERY OR CREMATORY: Loudon Pk.

22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: McCully Funeral Home — ADDRESS: 120 E Fayette

24a. REC'D BY REGISTRAR DATE: NOV 23 '59

24b. REGISTRAR'S SIGNATURE: Esther L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12130

CERTIFICATE OF DEATH

12144
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel Genera l Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 125 Market St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Roberta — Middle: ELLIOT — Last: MACALUSO

4. DATE OF DEATH: Month: November — Day: 26 — Year: 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: January 3, 1906
9. AGE (In years last birthday): 53 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Reg. Nurse
10b. KIND OF BUSINESS OR INDUSTRY: Reg Nurse
11. BIRTHPLACE (State or foreign country): TANEYTOWN MD
12. CITIZEN OF WHAT COUNTRY? U. S. A

13. FATHER'S NAME: CHARLES A ELLIOT
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.:
INFORMANT: MARY Jo LINDSAY — Address: (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Malignant neoplasm of unspecified site (199) — INTERVAL BETWEEN ONSET AND DEATH: 7 months
199.2
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from March, 1959, to Nov. 26, 1959, that I last saw the deceased alive on Nov. 26, 1959, and that death occurred at 1:05 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James R. Martin, M.D. — ADDRESS (Street, city or town, state): 6 Shaw St., Annapolis, Md. — DATE SIGNED: 11/27/59

PHYSICIAN'S NAME (Type): James R. Martin

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Nov 30-59
22c. NAME OF CEMETERY OR CREMATORY: St Mary's Cemt
22d. LOCATION (City, town, or county): Annapolis (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons — ADDRESS: Annapolis Md
24a. REC'D BY REGISTRAR DATE: DEC 1 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12178

CERTIFICATE OF DEATH

12145
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel, Maryland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION): Children's Center District Training School, Laurel, Md.

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C. 47 X 3
d STREET ADDRESS: 1404 - 22nd Street S.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF [illegible] (Type or print): First LOIS Middle MAE Last MANN

4. DATE OF DEATH: Month November Day 22, Year 1959

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept. 25, 1925
9 AGE (In years last birthday): 34 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Institution
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Georgia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Isham Wesley Mann
14. MOTHER'S MAIDEN NAME: Torpley Mann

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17 INFORMANT: Children's Center, Laurel, Md. (Address)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	cardiovascular collapse	
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	status epilepticus	2 hrs.
DUE TO (c)	Convulsive disorder	2 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): mongolism idiocy

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August, 1956, to Nov. 22, 59, that I last saw the deceased alive on 11/22/59, 19, and that death occurred at 1:55 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Wilfred R. Ehrmantraut M.D. ADDRESS (Street, city or town, state): Children's Center, Laurel, Md. DATE SIGNED: 11/24/59

PHYSICIAN'S NAME (Type): Wilfred R. Ehrmantraut, M.D. Children's Center, Laurel, Md. 11/24/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11-24-59
22c. NAME OF CEMETERY OR CREMATORY: D.T.S. Cemetery
22d. LOCATION (City, town, or county) (State): Laurel, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: John J Howe, Jr DTS Laurel Md ADDRESS
24a REC'D BY REGISTRAR DATE: NOV 27 '59
24b REGISTRAR'S SIGNATURE: Arthur L Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12179 Item 12 Fil. 62 2 11-16-59 et

12146

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

1. PLACE OF DEATH a. COUNTY: AA — MARYLAND	2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) a. STATE: MD b. COUNTY: AA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brooklyn — c. LENGTH OF STAY IN 1b:	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brooklyn 5a
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 108 Riverside Rd	d. STREET ADDRESS: 108 Riverside Rd — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
THOMAS	J.	Mc GUIGAN	11-	8-	1959

5. SEX	6 COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9 AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS Hours / Min.
M	W		Oct 29, 1888	71 yrs.		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Salesman		IRELAND	U.S.A.

13. FATHER'S NAME	14 MOTHER'S MAIDEN NAME
John Mc GUIGAN	Mc Donald

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16 SOCIAL SECURITY NO	17 INFORMANT	Address
NO	212-01-8797	Family	Same

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) myocardial infarction
DUE TO
(b) carcinomatosis - Ca prostate
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 177X

INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March, 1955 to Nov. 8, 1959, that I last saw the deceased alive on Nov. 8, 1959, and that death occurred at 2:00 A.M. from the causes and on the date stated above

ACTUAL SIGNATURE: Eugene Sylvester M.D. — ADDRESS (Street, city or town, state): 3904 S. Hanover St — DATE SIGNED: 11-10-59

PHYSICIAN'S NAME (Type): Eugene Sylvester — Balto. 23, Md.

22a BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	11-11-59	Holy Cross Cem	Brooklyn Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Mc Cully Funeral Hm 130 E Fayette	NOV 12 '59	Catherine S. Kraus

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12180

CERTIFICATE OF DEATH

12147

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1. PLACE OF DEATH — a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 2 years 7mo. 26 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) — a. STATE: Maryland — b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3V01 4.
d. STREET ADDRESS: Unknown
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Sarah — Middle: — Last: Miles

4. DATE OF DEATH: Month: 11 — Day: 12 — Year: 19 59

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1885?

9. AGE (In years last birthday): 74? yrs. — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (State or foreign country): Unknown

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unknown (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: Unknown

INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH:
422,1
DUE TO (b): Arteriosclerotic Cardiovascular Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---

20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19 —

20d. INJURY OCCURRED White at work ☐ Not white at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3/16 , 1957, to 11/12 , 1959, that I last saw the deceased alive on 11/12 , 19 59 , and that death occurred at 1:15 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Hildegard Heard Reiss M.D. — ADDRESS (Street, city or town, state): Crownsville State Hospital, Md. — DATE SIGNED: 11/12/59

PHYSICIAN'S NAME (Type): Hildegard Heard Reissman, M. D. — Crownsville State Hospital, Md. 11/12/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11/16/59

22c. NAME OF CEMETERY OR CREMATORY: Mt. Calvary Mem.

22d. LOCATION (City, town, or county): Cedar Hill (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: E. O. Wilson — ADDRESS: 1000 Brantley Ave.

24a. RECD BY REGISTRAR DATE: NOV 16 '59

24b. REGISTRAR'S SIGNATURE:

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12131

CERTIFICATE OF DEATH

12148

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: A.A. GENERAL HOSPT.

2. USUAL RESIDENCE (Where deceased lived If institutions Residence before admission)
a. STATE: MD
b. COUNTY: A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
d. STREET ADDRESS: 115 CHESTER AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FRANCIS Middle A. Last MITCHELL

4. DATE OF DEATH: Month 11 Day 23 Year 1959

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: AUG 29 1916

9. AGE (In years last birthday): 43 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ENGINEMAN

10b. KIND OF BUSINESS OR INDUSTRY: U.S.N.A.

11. BIRTHPLACE (State or foreign country): ANNAPOLIS MD

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: PHILLIP E. MITCHELL

14. MOTHER'S MAIDEN NAME: ELSIE MAE DOWNEY

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): WW II

16. SOCIAL SECURITY NO:

17. INFORMANT: HELEN C. MITCHELL Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INANITION, abdominal obstruction, ascites — INTERVAL BETWEEN ONSET AND DEATH: 4 months

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Malignant involvement, abdominal viscera — 3 yrs.

DUE TO

(c) Lymphosarcoma, diffuse — 4 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour / Month, Day, Year: a.m. / p.m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I **certify** that I attended the deceased from March, 1956, to Nov. 23, 1959, that I last saw the deceased alive on Nov. 23, 1959, and that death occurred at 7:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Merton T. Waite M.D — ADDRESS (Street, city or town, state): 121 Cathedral St. Annapolis, Md. — DATE SIGNED: 11-23-59

PHYSICIAN'S NAME (Type): MERTON T. WAITE

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: NOV 27 1959

22c. NAME OF CEMETERY OR CREMATORY: KILLCREST MEM.

22d. LOCATION (City, town, or county) (State): ANNAPOLIS MD

23. FUNERAL DIRECTOR'S SIGNATURE: JOHN M. TAYLOR-SON — ADDRESS: ANNAPOLIS MD

24a. REC'D BY REGISTRAR DATE: NOV 27 '59

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12132

12149

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS, Md.
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis Md
d. STREET ADDRESS: 72 Washington Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: HERBERT — Middle: — Last: MOBRAY

4. DATE OF DEATH: Month: NOV — Day: 11 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: Col

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12-25-1868

9. AGE (In years last birthday): 90 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer Shucker

10b. KIND OF BUSINESS OR INDUSTRY: M. Nasby Oyster Co

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Rose Mobray

14. MOTHER'S MAIDEN NAME: Elizabeth Mobray

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO: 216-12-6042

17. INFORMANT: GERALDINE MOBRAY — Address: Annapolis

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Pulmonary Edema due to
DUE TO (b): Chronic Interstitial Fibrosis of Lungs
DUE TO (c): Old Age

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 44

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senility

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/23/59 to 11/11/59, that I last saw the deceased alive on 11/11/59, and that death occurred at 7:57 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R. L. Richardson M.D. — ADDRESS (Street, city or town, state): 110 Clay St Annapolis, Md. — DATE SIGNED: 11/11/59

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 11-14-59

22c. NAME OF CEMETERY OR CREMATORY: Brewer Hill

22d. LOCATION (City, town, or county): Annapolis — (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: William Reese — ADDRESS: #108 Wash. St. Annapolis Md.

24a. REC'D BY REGISTRAR DATE: NOV 17 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12133

CERTIFICATE OF DEATH

12151

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b COUNTY: Anne Arundel

b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis

c. LENGTH OF STAY IN 1b: 15 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewater

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

d. STREET ADDRESS: Silby on the Bay

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Beulah — Middle: L. — Last: Mundell

4. DATE OF DEATH: Month: Nov. — Day: 25th — Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5/13/1883

9. AGE (In years last birthday): 76 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: at Home

11. BIRTHPLACE (State or foreign country): Riverview, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: James? Jones

14. MOTHER'S MAIDEN NAME: Selina Spencer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO: 577-50-3725

INFORMANT: Mildred Patterson, Daughter — Address: above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Uremia with renal insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 7 days

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): Congestive heart failure — 3 weeks

DUE TO

(c): Hypertensive cardiovascular disease — several years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from Aug. 15, 1959 to Nov. 25, 1959, that I last saw the deceased alive on Nov. 25, 1959, and that death occurred at 10:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Sylvia M. Lim M.D. — ADDRESS (Street, city or town, state): RFD #1 Box 277-M — DATE SIGNED: 11-26-59

PHYSICIAN'S NAME (Type): Sylvia M. Lim — Edgewater, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11/28/59

22c. NAME OF CEMETERY OR CREMATORY: Congressional

22d. LOCATION (City, town, or county) (State): Washington, D.C.

23 FUNERAL DIRECTOR'S SIGNATURE: Malloy's Funeral Home, Inc.

ADDRESS: Mt. Rainier, Md.

24a. REC'D BY REGISTRAR DATE: NOV 30 '59

24b. REGISTRAR'S SIGNATURE: C. Edwin L. Krantz

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12134

CERTIFICATE OF DEATH

12152

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 1 hour
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural - Annapolis
d. STREET ADDRESS: Revell Highway
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First JACOB — Middle DONALDSON — Last PARR

4. DATE OF DEATH: Month November — Day 20 — Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: October 18, 1906

9. AGE (In years last birthday): 53 yrs

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Real Estate Promoter

10b. KIND OF BUSINESS OR INDUSTRY: Self

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Jacob S. Parr

14. MOTHER'S MAIDEN NAME: Sarah Delcher

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.

INFORMANT Address: Mrs. Nancy Anne Parr-Annapolis, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 3 hrs
DUE TO
(b): Coronary Artery sclerosis — 5 yrs.
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1955, to Nov, 1959, that I last saw the deceased alive on Nov 20, 1959, and that death occurred at 11:50 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John L Hedeman M.D.
ADDRESS (Street, city or town, state): 121 Cathedral St., Annapolis, Md.
DATE SIGNED: 11/20/59
PHYSICIAN'S NAME (Type): John L. Hedeman

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11/24/59
22c. NAME OF CEMETERY OR CREMATORY: Woodlawn Cemetery
22d. LOCATION (City, town, or county) (State): Woodlawn, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible]
ADDRESS: [illegible]

24a. REC'D BY REGISTRAR DATE: NOV 23 '59
24b. REGISTRAR'S SIGNATURE: Ursula S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12135

CERTIFICATE OF DEATH

12153

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY A. A. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS
c. LENGTH OF STAY IN 1b 34 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 51 5th Street

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a STATE Md. b COUNTY A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 ANNAPOLIS
d. STREET ADDRESS 51 5th Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Charles Middle Lee Last Pinkerson
4. DATE OF DEATH Month 12 Day 2 Year 1959
5. SEX M
6. COLOR OR RACE C
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Apr. 5-85
9. AGE (In years last birthday) 74 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FISHERMAN
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) ANNAPOLIS, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Julia Crowdy
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or Unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 214-05-2397
17. INFORMANT Address Felix T. Pinkerson Annapolis Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Stomach
151X
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11-26-59, 19, to 11-29-59, 19, that I last saw the deceased alive on 11-28-59, 19, and that death occurred at 5:44 M, from the causes and on the date stated above.

ACTUAL SIGNATURE G. T. Coates M.D. ADDRESS (Street, city or town, state) 62 Cathedral St DATE SIGNED
PHYSICIAN'S NAME (Type) A T ALLEN Annapolis Md

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 12-3-59
22c. NAME OF CEMETERY OR CREMATORY Annapolis Mem'l
22d. LOCATION (City, town, or county) (State) Annapolis Md.

23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Hicks ADDRESS Annapolis Md.
24a. REC'D BY REGISTRAR DATE DEC 3 '59
24b. REGISTRAR'S SIGNATURE Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS 15 (4) 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 D , Film [illegible] 11/13/59 lwk

12181

CERTIFICATE OF DEATH

12154

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel Co. — Md. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen-burnie
c. LENGTH OF STAY IN 1b: 9 Mo.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Plaza Manor Convalescent Home

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen-Burnie
d. STREET ADDRESS: 1046 Pennsylvania Ave — None — Balto. 2, Md.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Clara — Last: Powell

4. DATE OF DEATH: Aug. — Month: Aug — Day: 30, — Year: 1959

5 SEX: FeMale
6. COLOR OR RACE: C
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Aug. 8, 1895
9. AGE (In years last birthday): 64 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: NONE
11. BIRTHPLACE (State or foreign country): Anacosia Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.

13 FATHER'S NAME: Charles Thompson
14. MOTHER'S MAIDEN NAME: Delia Thompson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16 SOCIAL SECURITY NO:
17. INFORMANT — Address: Mrs. Cherry Powell 1048 Penna. Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic heart disease with aortic stenosis. — INTERVAL BETWEEN ONSET AND DEATH: & ? yrs.

420.0

DUE TO:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Adenocarcinoma of thyroid, probable. Chronic brain syndrome.

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January 5, 1959 to November 9, 1959 that I last saw the deceased alive on November 7, 1959, and that death occurred at 10:15 M. from the causes and on the date stated above.

ACTUAL SIGNATURE: James M. Pair M.D.
ADDRESS (Street, city or town, state): 400 N. Carrollton Ave. Baltimore 23, Maryland
DATE SIGNED: November10,'59
PHYSICIAN'S NAME (Type): James M. Pair, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11/13/59
22c. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cemetery
22d. LOCATION (City or town, or county) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: William A. Jackson 916 Penna. Ave.
24a. REC'D BY REGISTRAR DATE: NOV 12 59
24b. REGISTRAR'S SIGNATURE: Catherine L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12182

CERTIFICATE OF DEATH

12155 Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Shady Side
c. LENGTH OF STAY IN 1b: life time
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x Shady Side
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Fredus Middle Edmund Last Proctor

4. DATE OF DEATH: Month November Day 23 Year 1959

5. SEX: Male

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6/17/96

9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): WATERMAN

10b. KIND OF BUSINESS OR INDUSTRY: Sea Food

11. BIRTHPLACE (State or foreign country): Shadyside Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George Westey Proctor

14. MOTHER'S MAIDEN NAME: Ida Virginia Lee

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW I

16. SOCIAL SECURITY NO:

17. INFORMANT: Lucy A Proctor — Address: Shadyside Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of larynx
161x
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH: 2 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March, 1959, to Nov. 23, 1959, that I last saw the deceased alive on Nov. 22, 1959, and that death occurred at 1:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Willard F Smith M.D. ADDRESS (Street, city or town, state): Shady Side, Md. DATE SIGNED: 11/24/59

PHYSICIAN'S NAME (Type): WILLARD F SMITH, MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11/27/59

22c. NAME OF CEMETERY OR CREMATORY: ARLINGTON National

22d. LOCATION (City, town, or county) (State): Fort Myer, Va

23. FUNERAL DIRECTOR'S SIGNATURE: Bernard Hardesty ADDRESS: Edgewater Md

24a. REC'D BY REGISTRAR DATE: NOV 30 '59

24b. REGISTRAR'S SIGNATURE: Carlton S. Krause

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12183 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 8,11,13,14,16 rillG251 11-6-59 et

12156
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SEVERN
c. LENGTH OF STAY IN 1b: FEW MINUTES
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): ROUTE 554 ON WAY TO FGGM HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: VIRGINIA
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): NORFOLK
d. STREET ADDRESS: USS VULCAN AR 5
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROBERT; Middle; Last QUIGLEY

4. DATE OF DEATH: Month NOV; Day 1; Year 1959

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 27, 1938

9. AGE (In years last birthday): 21 yrs
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if ret red): US Naval dental tech.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Lansing, Michigan

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Donald Quigley

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): In US Navy at present

16. SOCIAL SECURITY NO.: 376-38-3756

17. INFORMANT: RICHARD JAMES OSTHEIM (FRIEND) — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Fractured skull
823X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Car ran off road and turned over.

20c. TIME OF INJURY: Hour 1130 p. m. Month, Day, Year Oct 31 1959

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Route 554

20f. (City or town) SEVERN (County) A A COUNTY (State) MD.

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gustave H. Faubert M.D — CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED

EXAMINER'S NAME (Type): GUSTAVE H. FAUBERT — 1 Nov 59

22a. BURIAL CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 11/3/59
22c. NAME OF CEMETERY OR CREMATORY: Lansing
22d. LOCATION (City, town, or county) (State): Michigan

23. FUNERAL DIRECTOR'S SIGNATURE: L. A. Clark Son
ADDRESS: Va.

24a. REC'D BY REGISTRAR DATE NOV 3 '59
24b. REGISTRAR'S SIGNATURE: Arthur E. Thomas

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12184 **CERTIFICATE OF DEATH** Reg. Dist. No. 12157

1 PLACE OF DEATH
a. COUNTY: Anne ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 1mo. 17 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimove
d. STREET ADDRESS: 219 E. Federal Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Richard — Middle — Last Rice
4. DATE OF DEATH: Month 11 — Day 11 — Year 19 59

5. SEX	6. COLOR OR RACE	7 MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS Hours / Min.
Male	Negro	NEVER MARRIED ☒	1900	59 yrs		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Unknown	--------	Unknown	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Unknown	Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	INFORMANT	Address
Unknown	Unknown	Hospital Records	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH

020.2

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause ost.

DUE TO (b) Bulbar Paralysis

DUE TO (c) Congenital Syphilis with Gumma of Brain

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---------

20c. TIME OF INJURY Month, Day, Year; Hour a. m. / p. m.	20d INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
-- - 19		-	- - -

21. I certify that I attended the deceased from 9/24, 19 59 to 11/11, 19 59 that I last saw the deceased alive on 11/11, 19 59 and that death occurred at 9:30 P.M. from the causes and on the date stated above

ACTUAL SIGNATURE: Hildegard Heard Reissman M.D. — ADDRESS (Street, city or town, state): Crownsville State Hospital, Md. — DATE SIGNED: 11/12/59

PHYSICIAN'S NAME (Type): Hildegard Heard Reissman, M.D. — Crownsville State Hospital, Md. — 11/12/59

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	11-16-59	Arbutus Mem. Park	Arbutus Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Milton E. Ebichon — ADDRESS: 1129 N. Caroline St.

24a. REC'D BY REGISTRAR DATE: NOV 18 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12136 **CERTIFICATE OF DEATH** Reg. Dist. No. 12158

1. PLACE OF DEATH
a. COUNTY ANNE ARUNDEL MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS
c. LENGTH OF STAY IN 1b LIFE
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) 15 EASTERN AVE.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY A.A. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS
d. STREET ADDRESS 15 EASTERN AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First C. Middle CORNER Last RIDOUT
4. DATE OF DEATH Month 11 Day 7 Year 1959
5. SEX M
6. COLOR OR RACE W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 11-3-1891
9. AGE (In years last birthday) 68 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN
10b. KIND OF BUSINESS OR INDUSTRY CLOTHING STORE
11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME CHARLES RIDOUT
14. MOTHER'S MAIDEN NAME CARRIE CORNER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) — (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO
17. INFORMANT VIVA P. RIDOUT Address #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CORONARY THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH 30 MINUTES
420.1
DUE TO
(b) ARTERIOSCLEROTIC CORONARY ARTERY DIS. — 10 YEARS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 11-1, 1959 to 11-1, 1959 that I last saw the deceased alive on 11-1, 1959 and that death occurred at 1:15 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE Edward L. Beck M.D. ADDRESS (Street, city or town, state) 41 Southgate Ave DATE SIGNED 11/2/59
PHYSICIAN'S NAME (Type) ANNAPOLIS MD

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF 11-4-59
22c. NAME OF CEMETERY OR CREMATORY St. MARGARETS
22d. LOCATION (City, town, or county) St. MARGARETS (State) MD.

23. FUNERAL DIRECTOR'S SIGNATURE John M. Gerdes ADDRESS Annapolis, Md.
24a. REC'D BY REGISTRAR DATE NOV 4 '59
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12185 **CERTIFICATE OF DEATH** Reg. Dist. No. 12159

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 7 years 4mo. 13 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3V21-4
d. STREET ADDRESS: 713 Brune Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Ada — Middle — Last Robinson
4. DATE OF DEATH: Month 10 — Day 6 — Year 1959
5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 1900
9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY: ----------
11. BIRTHPLACE (State or foreign country): South Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John Bell
14. MOTHER'S MAIDEN NAME: Sally Jackson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: Unknown
INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Thrombophlebitis of vena cava inferior with complete occlusion — INTERVAL BETWEEN ONSET AND DEATH
605X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (b): Thrombophlebitis of vesical plexus
DUE TO (c): Purulent cystitis and ureteritis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): Syphilitic cardiovascular disease
097
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -------
20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19—
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 5/23, 1952, to 10/6, 1959, that I last saw the deceased alive on 10/6, 1959 and that death occurred at 6:35A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Hildegard Heard Reissman M.D. — ADDRESS (Street, city or town, state): Crownsville State Hospital, Ma. — DATE SIGNED: 10/6/59
PHYSICIAN'S NAME (Type): Hildegard Heard Reissman, M. D. — Crownsville State Hospital, Md. 10/6/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11-10-59
22c. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cem
22d LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Frances Hemely — ADDRESS: 5778 W Baltimore
24a. REC'D BY REGISTRAR DATE: NOV 12 '59
24b. REGISTRAR'S SIGNATURE: C. Elmer L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12186 — Reg. Dist. No. 12160

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fort Geo G. Meade
c. LENGTH OF STAY IN 1b: 30 minutes
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Bldg. 9800 Savage Road NSA Oper. Bldg.

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): College Park
d. STREET ADDRESS: 4709 Blackfoot Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BENJAMIN — Middle D. — Last SCHULTZ
4. DATE OF DEATH: Month November — Day 10 — Year 1959

5. SEX: Male
6. COLOR OR RACE: Cau
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug 4 1894
9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter Foreman
10b. KIND OF BUSINESS OR INDUSTRY: U S Government
11. BIRTHPLACE (State or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph Schultz
14. MOTHER'S MAIDEN NAME: Mary Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW I
16. SOCIAL SECURITY NO.: 106-09-8811
17. INFORMANT: Mr. James C. Stanier — Address: NSA Oper. Bldg.

MED CAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
4-20-1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Gustave H Faubert MD M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED
EXAMINER'S NAME (Type): GUSTAVE H. FAUBERT, MD — 10 Nov 59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Nov 16, 1959
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or county) (State): Arlington Virginia

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: F. Gasch's Sons Hyattsville Maryland.
24a. REC'D BY REGISTRAR DATE: NOV 13 '59
24b. REGISTRAR'S SIGNATURE: Arthur L Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12137

CERTIFICATE OF DEATH

12161

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: E ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS, MD.
c. LENGTH OF STAY IN 1b: 1½ hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: NAVAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS, MARYLAND
d. STREET ADDRESS: 19 Goodrich Rd.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BABY GIRL Middle SCHURR Last

4. DATE OF DEATH: Month 11 Day 13 Year 1959

5. SEX: Female
6. COLOR OR RACE: Cauc.
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-13-59
9. AGE (In years last birthday) yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours 1½ / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Thomas Paul SCHURR
14. MOTHER'S MAIDEN NAME: Vilma D'AVI

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT: (F) T.P. SCHURR, 19 Goodrich Rd., Address Annapolis, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): DIAPHRAGMATIC HERNIA — INTERVAL BETWEEN ONSET AND DEATH: 1½
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): NO AUTOPSY DONE—SURGERY WAS PERFORMED
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11-20 11-13, 1959 to 11-30 11-13 1959 that I last saw the deceased alive on 11-13, 1959, and that death occurred at 2330 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: F. M. Kenny M.D. ADDRESS (Street, city or town, state): U.S. NAVAL HOSPITAL, ANNAPOLIS, MARYLAND DATE SIGNED

PHYSICIAN'S NAME (Type): F.M. KENNY LT MC USNR U.S. NAVAL HOSPITAL, ANNAPOLIS, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11-16-59
22c. NAME OF CEMETERY OR CREMATORY: Naval Academy
22d. LOCATION (City, town, or county): Annapolis (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons ADDRESS: Annapolis Md.
24a. REC'D BY REGISTRAR DATE: NOV 20 '59
24b. REGISTRAR'S SIGNATURE: Clinton S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
ISM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12138

CERTIFICATE OF DEATH

12162
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Linthicum Heights
f. STREET ADDRESS: 234 Hammonds Ferry Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First UNNAMED Middle Last SCHUTTENHELM
4. DATE OF DEATH: Month November Day 20 Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: November 19, 1959
9. AGE (In years last birthday) yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours 20 — Min. 58

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Roger Edward SCHUTTENHELM
14. MOTHER'S MAIDEN NAME: Jane Sophie KRAUS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Prematurity
DUE TO
776x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p m Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I **certify** that I attended the deceased from Nov 19, 1959 to Nov 20, 1959, that I last saw the deceased alive on Nov 19, 1959, and that death occurred at 6:25 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Neil H. Sims, M.D.
ADDRESS (Street, city or town, state): 95 Cathedral St., Annapolis, Md.
DATE SIGNED: 11/20/59
PHYSICIAN'S NAME (Type): Neil H. SIMS

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11-21-59
22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Memorial
22d. LOCATION (City, town, or county) (State): Annapolis, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Hopping Funeral Home
ADDRESS: Annapolis, Md.
24a. REC'D BY REGISTRAR DATE: NOV 23 '59
24b REGISTRAR'S SIGNATURE: Arthur S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12187

CERTIFICATE OF DEATH

12163

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): St. Margarets
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Revell Highway

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: A.A. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): St. Margarets
d. STREET ADDRESS: Revell Highway
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Maude Minnick — Last: Scott

4. DATE OF DEATH: Month: 11 — Day: 26 — Year: 1959

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7-19-1881

9. AGE (In years last birthday): 78 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George R. Minnick

14. MOTHER'S MAIDEN NAME: Patricia Staler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: J. Carroll Scott — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Congestive Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: about 6 hrs

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Chronic Arterial Hypertension — many yrs.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Month, Day, Year — Hour: o. m / p. m — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from Nov 9th, 1959 to Nov 26, 1959, that I last saw the deceased alive on Nov 26th, 1959, and that death occurred at 4 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: J. Oliver Purvis M.D. — ADDRESS (Street, city or town, state): 40 Franklin St, Annapolis, Md. — DATE SIGNED: 11/27/59

PHYSICIAN'S NAME (Type): J. Oliver Purvis.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11-29-59

22c. NAME OF CEMETERY OR CREMATORY: St. Margarets

22d. LOCATION (City, town, or county): St. Margarets (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Perry M. Ley Son Inc. — ADDRESS: Annapolis, Md.

24a. REC'D BY REGISTRAR DATE: DEC 1 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12139

12164

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived — If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 99 Cathedral St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: C — Last: SELLERS

4. DATE OF DEATH: Month: November — Day: 25 — Year: 19 59

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: November 8, 1891

9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nurse wife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Indiana

12 CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: J. M Dugan

14. MOTHER'S MAIDEN NAME: Robinson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service):

16. SOCIAL SECURITY NO.:

INFORMANT: Howard Sellers — Address: (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ADRENAL INSUFFICIENCY — INTERVAL BETWEEN ONSET AND DEATH: 48 HOURS
DUE TO (b): CELLULITIS OF BUTTOCKS — 7 DAYS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): DIABETES MELLITUS — 10 YRS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): ACUTE RHEUMATOID ARTHRITIS; ACUTE GASTRO-ENTERITIS

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I attended the deceased from Nov. 22, 1959, to Nov. 24, 1959, that I last saw the deceased alive on Nov. 24, 1959, and that death occurred at 6:05A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward S Beck M.D. — ADDRESS (Street, city or town, state): 41 Southgate Ave., Annapolis, Md. — DATE SIGNED: 11/25/59

PHYSICIAN'S NAME (Type): Edward S. Beck

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: 11-28-59
22c NAME OF CEMETERY OR CREMATORY: Floral Park
22d LOCATION (City, town, or county) (State): Indianapolis Ind

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons — ADDRESS: Annapolis Md.

24a. REC'D BY REGISTRAR DATE: NOV 27 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12188

CERTIFICATE OF DEATH

12165
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel, Md.
c. LENGTH OF STAY IN 1b: 29 years
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION): Children's Center — District Training School — Laurel, Md.

2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C.
d. STREET ADDRESS: 923 Shepherd Street N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Paul — Middle: J. — Last: Sexton

4. DATE OF DEATH: Month: November — Day: 17, — Year: 1959

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov. 10, 1899
9. AGE (In years last birthday): 60 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Institution
10b. KIND OF BUSINESS OR INDUSTRY: -
11 BIRTHPLACE (State or foreign country): North Dakota
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edward J. Sexton
14. MOTHER'S MAIDEN NAME: Margaret

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16 SOCIAL SECURITY NO: --
17 INFORMANT: Children's Center, Laurel, Md. (Address)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 week
491X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Bronchial asthma, hypogonadism, mental retardation
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August, 1956 to Nov. 17, 1959 that I last saw the deceased alive on Nov 17 7:50 A.M., 1959, and that death occurred at 7:50 A.M., from the causes and on the date stated above.
ACTUAL SIGNATURE: Wilfred R. Ehrmantraut M.D. — ADDRESS (Street, city or town, state): Children's Center, Laurel, Md. — DATE SIGNED: 11/18/59
PHYSICIAN'S NAME (Type): Wilfred R. Ehrmantraut, M.D. — Children's Center, Laurel, Md. — 11/18/59

22a BURIAL, CREMATION, REMOVAL (Specify): 22b. DATE THEREOF: 11/19/59
22c NAME OF CEMETERY OR CREMATORY: DTS Cemetery
22d. LOCATION (City, town, or county) (State): Laurel Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John J Mone Jr Supt DTS — ADDRESS: Laurel, Md
24a. REC'D BY REGISTRAR: DATE NOV 25 '59
24b. REGISTRAR'S SIGNATURE: Esther S Kuns

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12140

12166

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 4mo. 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severn
d. STREET ADDRESS: Route 2, Box 195
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Edward; Middle; Last Smith

4. DATE OF DEATH: Month 11; Day 18; Year 19 59

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 7, 1901

9. AGE (In years last birthday): 58 yrs.

IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed

10b. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Tom Smith

14. MOTHER'S MAIDEN NAME: Ella

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 217-09-8984

17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Broncho-Pneumonia — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO (b): Arteriosclerotic Cardiovascular Disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Diabetes Mellitus

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Brain Syndrome Associated with Metabolism Disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---

20c. TIME OF INJURY: Hour; a. m. p. m.; Month; Day; Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/17, 19 59, to 11/18, 19 59, that I last saw the deceased alive on 11/18, 19 59, and that death occurred at 3:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Hildegard Heard Reissman M.D.
ADDRESS (Street, city or town, state): Crownsville State Hospital, Md.
DATE SIGNED: 11/19/59

PHYSICIAN'S NAME (Type): Hildegard Heard Reissman, M. D.
Crownsville State Hospital, Md. 11/19/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Nov. 23, 1959
22c. NAME OF CEMETERY OR CREMATORY: Arbutus Memorial Pk.
22d. LOCATION (City, town, or county) (State): Baltimore Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Arthur L. Mans Funeral Home
ADDRESS: 1031 Maiden Hill Ave.

24a. REC'D BY REGISTRAR DATE: NOV 23 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Mans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12182

CERTIFICATE OF DEATH

12167
Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mayo
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Mayo
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Lewis — Middle: H. — Last: Smith

4. DATE OF DEATH: Month: Nov. — Day: 23 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb.28.1885

9. AGE (In years last birthday): 74 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret

10b. KIND OF BUSINESS OR INDUSTRY: Printer

11. BIRTHPLACE (State or foreign country): Miss.

12 CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Edwaed H. Smith

14. MOTHER'S MAIDEN NAME: Mary. Dilly

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

INFORMANT: Richard. Smith — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 3 minutes

420.1

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Hypertensive cardiovascular disease — Several years

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. Month, Day, Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street office bldg. etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 30, 1959, to Oct. 28, 1959, that I last saw the deceased alive on Nov. 23, 1959, and that death occurred at 5:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Sylvia M. Lim M.D. — ADDRESS (Street, city or town, state): RFD #1, Box 277-M — DATE SIGNED: 11-23-59

PHYSICIAN'S NAME (Type): Sylvia M. Lim — Edgewater, Md.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11.25.59

22c. NAME OF CEMETERY OR CREMATORY: Fort.Lincoln

22d. LOCATION (City, town or county) (State): Colmar.Manor Md

23. FUNERAL DIRECTOR'S SIGNATURE: Lee Funeral Home — ADDRESS: 300.4th st N E.

24a. REC'D BY REGISTRAR DATE: NOV 25 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Rivers

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12198

12168 Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1. PLACE OF DEATH — a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 1 month
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) — a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Aire
d. STREET ADDRESS: ?
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Millie — Middle: Elizabeth — Last: Smith

4. DATE OF DEATH: Month: 11 — Day: 9 — Year: 1959

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1877, Mar 2nd.

9. AGE (In years last birthday): 82 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ~~Farm~~ House Keeper

10b. KIND OF BUSINESS OR INDUSTRY: Civil Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Daniel Smith

14. MOTHER'S MAIDEN NAME: Caroline Shewsbury

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 136-26-5532A

INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Infarct
420.1
DUE TO
(b): Chronic Arteriosclerotic Cardiovascular Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO
(c): Generalized and Cerebral Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Brain Syndrome due to Arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour — a. m. p. m. — Month — Day — Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/9 19 59 to 11/9 19 59, that I last saw the deceased alive on 11/9 19 59, and that death occurred at 9:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Lionel McHenry Mapp M.D. — ADDRESS (Street, city or town, state): Crownsville State Hospital, Md. — DATE SIGNED: 11/9/59

PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M. D. — Crownsville State Hospital, Md. — 11/9/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11/12/1959

22c. NAME OF CEMETERY OR CREMATORY: Union Methodist

22d. LOCATION (City, town, or county) (State): Aberdeen Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: John G. Barnes — ADDRESS: Aberdeen Md.

24a. REC'D BY REGISTRAR DATE: NOV 16 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Evans

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12141

CERTIFICATE OF DEATH

Reg. Dist. No. 12169

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 33 West Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Marylland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Annapolis
d. STREET ADDRESS: 33 West Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WITASKI — Middle V — Last SNYDER

4. DATE OF DEATH: Month NOVEMBER — Day 17 — Year 19 59

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: ? ? , 1880

9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Poland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): nO
(If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

INFORMANT — Address: Morris Snyder- Son- Same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.

420.0

DUE TO (b): Arteriosclerotic Heart Disease — 6 months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 1, 1959, to 11/16/, 1959, that I last saw the deceased alive on 11-16- 1959, and that death occurred at 7?? M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James R. Martin M.D. — DATE SIGNED: November 17, 1959

PHYSICIAN'S NAME (Type): James R. Martin MD — ADDRESS (Street, city or town, state): 6 Shaw Street Annapolis, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Nov. 18, 1959

22c. NAME OF CEMETERY OR CREMATORY: Kneseth Israel Cemetery

22d. LOCATION (City, town, or county) (State): Annapolis, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE, ADDRESS: Hopping Funeral Home Annapolis, Maryland

24a. REC'D BY REGISTRAR DATE: NOV 20 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kinnear

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

M

I

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12191

CERTIFICATE OF DEATH

12170

Reg. Dist. No.

1 PLACE OF DEATH ■ COUNTY: ANNE ARUNDEL — MARYLAND

b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ARNOLD

c. LENGTH OF STAY IN 1b: 3 YEAR

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 10 HARMONY AVE

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: MD
b. COUNTY: U.I.
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ARNOLD
d STREET ADDRESS: 10 HARMONY
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First EDITH Middle TIFFANY Last TARR

4. DATE OF DEATH: Month NOV. Day 27 Year 1959

5 SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct 8, 1903

9. AGE (In years last birthday): 56 yrs

IF UNDER 1 YEAR: Months ____ Days ____ IF UNDER 24 HRS: Hours ____ Min. ____

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b KIND OF BUSINESS OR INDUSTRY: at Home

11. BIRTHPLACE (State or foreign country): Baltimore Md

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry William Johnson

14. MOTHER'S MAIDEN NAME: Elizabeth

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: 217-05-5303

INFORMANT: MR GEORGE L. TARR Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cerebro-vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 1 hr

443X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Hypertensive cardio-vascular disease — 6 yrs

DUE TO

(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour ____ o. m. p. m. Month, Day, Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that I attended the deceased from July, 1959, to Nov, 1959, that I last saw the deceased alive on 27 Nov, 1959, and that death occurred at 9 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Gene D. Trethin M.D. ADDRESS (Street, city or town, state): 715 Cotter Rd Glen Burnie Md DATE SIGNED: 28 Nov 59

PHYSICIAN'S NAME (Type): GENE D. TRETHIN 715 COTTER Rd. GLEN BURNIE, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b DATE THEREOF: Dec 1, 1959

22c. NAME OF CEMETERY OR CREMATORY: Baltimore Cemetery

22d LOCATION (City, town, or county) (State): Baltimore Md

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: HENRY S'ANDER & SONS INC. BALTIMORE MD

24a. REC'D BY REGISTRAR DATE: DEC 2 '59

24b. REGISTRAR'S SIGNATURE: Arthur J. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12171

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH — 12142
   a. COUNTY: ANNE ARUNDEL — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
   c. LENGTH OF STAY IN 1b
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 2090 Forest Drive

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: MARYLAND — b. COUNTY: ANNE ARUNDEL
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
   d. STREET ADDRESS: Apt. 6, Carver Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: LOTTIE — Middle — Last: THOMAS

4. DATE OF DEATH: Month: November — Day: 13 — Year: 1959

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 9-17-1915

9. AGE (In years last birthday): 44 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waitress

10b. KIND OF BUSINESS OR INDUSTRY: Restaurant

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Samuel Jones

14. MOTHER'S MAIDEN NAME: Queenie Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 219-07-3337

17. INFORMANT — Address: Lena Jones Mayo Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Gunshot wound of right temple

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: Partial

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Shot self in head

20c. TIME OF INJURY — Hour: 8:15 a.m. xxx — Month, Day, Year: 11/13 1959

20d. INJURY OCCURRED — While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town): Annapolis — (County): Anne Arundel — (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒. Inspection ☐. Inquiry ☐. and in my opinion death resulted from: Natural causes ☐. Accident ☐. Suicide ☒. Homicide ☐. Undetermined manner ☐

ACTUAL SIGNATURE: W. Bradley King Jr. M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type): W. Bradley King, Jr., M.D.

Address (Street, city, town, or county):

DATE SIGNED: 11/13/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11-17-59

22c. NAME OF CEMETERY OR CREMATORY: Brewer Hill

22d. LOCATION (City, town, or country): Annapolis (State): Md.

23. FUNERAL DIRECTOR — ADDRESS: William Reese ft. 108 Wash. St. Ann. Md.

24a. REC'D BY REGISTRAR — DATE: NOV 17 '59

24b. REGISTRAR'S SIGNATURE: Clarence A. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12143

CERTIFICATE OF DEATH

12172

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Annapolis
d. STREET ADDRESS: 518 2nd St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Lawrence — Middle R. — Last TUERS

4. DATE OF DEATH: Month November — Day 25, — Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 1, 1898
9. AGE (In years last birthday): 61 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Paperhanger
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Naval Academy
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Arthur M. Tuers
14. MOTHER'S MAIDEN NAME: Emma M. Rutter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: —
INFORMANT: Viola A. Tuers — Address: (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Coronary Thrombosis & Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 30 minutes
420.1
DUE TO (b): Arteriosclerotic Coronary Art. Disease — unknown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus; Esophageal Varices; Hematuria, Cause Unknown
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Nov. 20, 1959, to Nov. 25 1959, that I last saw the deceased alive on Nov. 25, 1959, and that death occurred at 10:20 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward S. Beck M.D.
ADDRESS (Street, city or town, state): 41 Southgate Ave., Annapolis, Md.
DATE SIGNED: 11/25/59
PHYSICIAN'S NAME (Type): Edward S. Beck

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Nov 28-59
22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery
22d. LOCATION (City, town, or county) (State): Annapolis Md

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons
ADDRESS: Annapolis Md
24a. REC'D BY REGISTRAR DATE: DEC 1 59
24b. REGISTRAR'S SIGNATURE: Arthur L. Franz

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12144

CERTIFICATE OF DEATH

Reg. Dist. No. 12173

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 9 hours
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: A. A. Gen. Hospital

2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Edgewater
d. STREET ADDRESS: 103 Valley View Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Mark — Middle Allen — Last VANSCOY
4. DATE OF DEATH: Month November — Day 1 — Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: October 31, 1959
9. AGE (In years last birthday) yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours 9 — Min. 11

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Perry Edward VANSCOY
14. MOTHER'S MAIDEN NAME: Peggy Marie HOAGLAND

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
INFORMANT Address: Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity
DUE TO
(b)
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 31, 1959, to Nov. 1, 1959 that I last saw the deceased alive on Nov. 1, 1959, and that death occurred at 3:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edith Rodler M.D.
ADDRESS (Street, city or town, state): 45 Franklin St., Annapolis, Md.
DATE SIGNED: 11/2/59
PHYSICIAN'S NAME (Type): Edith Rodler

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 11-2-59
22c. NAME OF CEMETERY OR CREMATORY: HILLCREST
22d. LOCATION (City, town, or county) (State): ANNAPOLIS Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor & Sons
ADDRESS: Annapolis, Md.
24a. REC'D BY REGISTRAR DATE: NOV 4 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Hines

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 Fi... 1-16-54 et

12145

CERTIFICATE OF DEATH

Reg. Dist. No. 12174

1. PLACE OF DEATH
a. COUNTY Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 503 Burnside St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland — b. COUNTY A.A.Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis
d. STREET ADDRESS 503 Burnside St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Geraldine — Middle: V. — Last: Vodak
4. DATE OF DEATH — Month: 11 — Day: 4 — Year: 1959
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3-15-1914
9. AGE (In years last birthday): 45 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John F. Hirt
14. MOTHER'S MAIDEN NAME: (First name unknown) Skrevanek
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Edward M. Vodak — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Ca Breast c Metastasis — INTERVAL BETWEEN ONSET AND DEATH: 1958-1959
170 X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour o. m. / p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 1958, 19___, to Nov 4, 19 59, that I last saw the deceased alive on Nov 4, 19 59, and that death occurred at ___ A. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): Annapolis — DATE SIGNED: Nov 5

PHYSICIAN'S NAME (Type): E. Linhardt

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11-7-1959
22c. NAME OF CEMETERY OR CREMATORY: St. Mary's
22d. LOCATION (City, town, or county): Annapolis (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor & Sons — ADDRESS: Annapolis, Md.
24a. REC'D BY REGISTRAR — DATE: NOV 6 '59
24b. REGISTRAR'S SIGNATURE: Cathy S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the coroner or medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 6 Film G253 12/3/59 lwk

12146

CERTIFICATE OF DEATH

12175

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: A.A. GENERAL Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
d. STREET ADDRESS: 36 E. GLEN AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First THELMA — Middle [redacted] — Last WESTERVELT

4. DATE OF DEATH: Month 11 — Day 22 — Year 1959

5. SEX: F

6. COLOR OR RACE: WW White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 2-10-1895

9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY: SAME

11. BIRTHPLACE (State or foreign country): TROY N.Y.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: EUGENE HYATT

14. MOTHER'S MAIDEN NAME: ANNA VAN KIRK

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: HENRY WESTERVELT

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Adrenal Cortical Failure — INTERVAL BETWEEN ONSET AND DEATH: 24 Hours

DUE TO (b): Carcinoma of Colon (operated) — 6 WKS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from APRIL, 1959, to 22 NOV, 1959, that I last saw the deceased alive on 22 NOV, 1959, and that death occurred at 2400 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward L Beck M.D. — ADDRESS (Street, city or town, state): 41 Southgate Ave Annapolis, Md. — DATE SIGNED: 11/22/59

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 11-25-59

22c. NAME OF CEMETERY OR CREMATORY: GLEN HAVEN MEM.

22d. LOCATION (City, town, or county) (State): GLEN BURNIE MD.

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Son — ADDRESS: Annapolis MD

24a. REC'D BY REGISTRAR DATE: NOV 27 '59

24b. REGISTRAR'S SIGNATURE: Catherine B. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death: Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12192

CERTIFICATE OF DEATH

Reg. Dist. No. 12176

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CROWNSVILLE
c. LENGTH OF STAY IN 1b: 1mo. 7 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: CROWNSVILLE STATE HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Annapolis
d. STREET ADDRESS: 10 Johnson Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary; Middle: ; Last: Wilson

4. DATE OF DEATH: Month: 11; Day: 17; Year: 19 59

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1876

9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: ---------

11. BIRTHPLACE (State or foreign country): Unknown Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown Thomas Hamilton

14. MOTHER'S MAIDEN NAME: Unknown Mary Hamilton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unknown
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO: Unknown

INFORMANT: Medical Records
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure
422.1
DUE TO (b): Arteriosclerotic Cardiovascular Disease with Aortic Aneurysm of Arteriosclerotic Origin
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/10, 1959, to 11/17, 19 59, that I last saw the deceased alive on 11/17, 19 59, and that death occurred at 12:10A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Lionel McHenry Mapp M.D.
ADDRESS (Street, city or town, state): Crownsville State Hospital, Md.
DATE SIGNED: 11/17/59

PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M. D.
Crownsville State Hospital, Md. 11/17/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremated
22b. DATE THEREOF: 11-20-59
22c. NAME OF CEMETERY OR CREMATORY: Bruce Hall
22d. LOCATION (City, town, or county) (State): Annapolis Md

23. FUNERAL DIRECTOR'S SIGNATURE: Wm Rees (11)
ADDRESS: 108 W Washington St

24a. REC'D BY REGISTRAR DATE: NOV 23 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kiana

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12193

CERTIFICATE OF DEATH

12177

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 14 years 8mo. 9 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Marlboro
d. STREET ADDRESS: Unknown
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First Gus — Middle — Last Young

4. DATE OF DEATH: Month 11 — Day 21 — Year 1959

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1889?

9. AGE (In years last birthday): 70? yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: ---------

11. BIRTHPLACE (State or foreign country): Unknown

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unknown (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: Unknown

17. INFORMANT — Address: Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac Failure Secondary to Syphilis — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b): Myocardial Infarct

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Generalized Arteriosclerosis - Diabetes Mellitus

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3/12, 1945 to 11/21, 1959, that I last saw the deceased alive on 11/21, 1959, and that death occurred at 11:10P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): Crownsville State Hospital, Md. — DATE SIGNED: 11/23/59

PHYSICIAN'S NAME (Type): Hildegard Heard Reissman, M.D. — Crownsville State Hospital, Md. — 11/23/59

22a BURIAL, CREMATION, REMOVAL (Specify): (REMOVAL)

22b. DATE THEREOF: 11/25/59

22c. NAME OF CEMETERY OR CREMATORY: University of Maryland

22d. LOCATION (City, town, or county) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Wm. Rexell Dove for the Wm. H. Dove Funeral Home — ADDRESS

24a. REC'D BY REGISTRAR — DATE NOV 27 '59

24b REGISTRAR'S SIGNATURE: Clifton L. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12147 **CERTIFICATE OF DEATH** Reg. Dist. No. 12178

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: hrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel Genera l Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Annapolis
d. STREET ADDRESS: 1 45 Calvert St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First William — Middle — Last YOUNG
4. DATE OF DEATH: Month November — Day 11 — Year 19 59

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: November 11, 1972
9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer - Building
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Edward Young
14. MOTHER'S MAIDEN NAME: Eliza - Gibson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
16. SOCIAL SECURITY NO.: UNKNOWN
INFORMANT: Josephine Young - 45 Calvert St. Address: Annapolis - Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage Hypertension
DUE TO (b): Cardiovascular Disease Grade III
DUE TO (c): Uremia, Pyelocystitis
443 ×
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertrophied Prostate
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov. 10, 1959, to Nov. 11, 1959, that I last saw the deceased alive on Nov. 10, 1959, and that death occurred at 12:45 AM, from the causes and on the date stated above.
ACTUAL SIGNATURE: R. L. Richardson M.D.
ADDRESS (Street, city or town, state): 110 Clay St., Annapolis, Md.
DATE SIGNED: 11/11/59
PHYSICIAN'S NAME (Type): R. L. Richardson

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11-14-59
22c. NAME OF CEMETERY OR CREMATORY: Brewer-Hill
22d. LOCATION (City, town, or county) (State): Annapolis - Md.
23. FUNERAL DIRECTOR'S SIGNATURE: Charles E. Hicks III ADDRESS: Annapolis - Md.
24a. REC'D BY REGISTRAR DATE: NOV 13 '59
24b. REGISTRAR'S SIGNATURE: Clinton L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12194

CERTIFICATE OF DEATH

12179

Reg. Dist. No. 23

1. PLACE OF DEATH
a. COUNTY 312 Broadmoor Blvd Glen Burnie MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie Md
c. LENGTH OF STAY IN 1b 10 years.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY A. A Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie Md.
d. STREET ADDRESS 312 Broadmoor Blvd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: William Middle: Henry Last: Feltman
4. DATE OF DEATH Month: Nov. Day: 8 Year: 19 59

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Dec 19. 1871
9. AGE (In years last birthday) 87 yrs.
IF UNDER 1 YEAR: Months — Days —
IF UNDER 24 HRS.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer. (Retired)
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Howard Co. Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Jacob Louis - Feltman -
14. MOTHER'S MAIDEN NAME: Lena - Weindl -

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. NONE
17. INFORMANT: Mrs. Adam Feltman Address: 312 Broadmoor Blvd Glen Burnie

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 3 weeks
DUE TO (b) Cardio. Vascular Disease — 4 years
DUE TO (c) —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) —
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —
20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19 —
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —
20f. (City or town) — (County) — (State) —

21. I certify that I attended the deceased from Oct 1, 19 59, to Nov 8, 19 59, that I last saw the deceased alive on Nov 7, 19 59, and that death occurred at 12 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE James S. Billingsley M.D. ADDRESS (Street, city or town, state) 108 Center Av Glen Burnie Md DATE SIGNED —
PHYSICIAN'S NAME (Type) James S. Billingsley M.D. 108 Center Av Glen Burnie Md

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF 11-11-59
22c. NAME OF CEMETERY OR CREMATORY St Johns Lutheran
22d. LOCATION (City, town, or county) (State) Pfeiffers Corner Md

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS F. C. Higinbotham Ellicott City Md
24a. REC'D BY REGISTRAR DATE NOV 13 '59
24b. REGISTRAR'S SIGNATURE Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55